

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **66 09001**

BIRTH NO. **66 09001**

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH E GAYNOR

2. DATE AND HOUR OF DEATH

SEPT 6 1966

1:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

20-23

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE CITY

D. STREET ADDRESS (If rural, give location)

412 SOUTH PAYSON ST.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-18-97

9. AGE (In years
lost birthday)

68

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALES Agent

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

BALTIMORE MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

PATRICK GAYNOR

14. MOTHER'S MAIDEN NAME

CATHERINE GILES

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

705-07-6405

17. INFORMANT

Mary E. Gaynor 412 S. Payson St.

ADDRESS

18.

443X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

**CEREBRO VASCULAR ACCIDENT,
(A) DUE TO EMBOLISM**

**(B) CEREBRAL ARTERIOSCLEROSIS
DUE TO**

**(C) HYPERTENSIVE CARDIO VASCULAR
DISEASE**

INTERVAL BETWEEN
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
Work

Not While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **1:15 PM 9-4 1966** to **1:00 AM 9-6-1966**
that (I) (we) last saw the deceased alive on **9-6-1966** and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Honorio R. Ylizarde Jr.

M.D.

Attending
Phys.

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

SEPT 6 1966

23C. PHYSICIAN'S
NAME (Type)

HONORIO R. YLIZARDE JR.

M.D.

23D. ADDRESS

FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

9-9-66

NEW Cathedral

BALTIMORE

MD

25A. DATE REC'D BY HEALTH DEPT.

SEP 7 1966

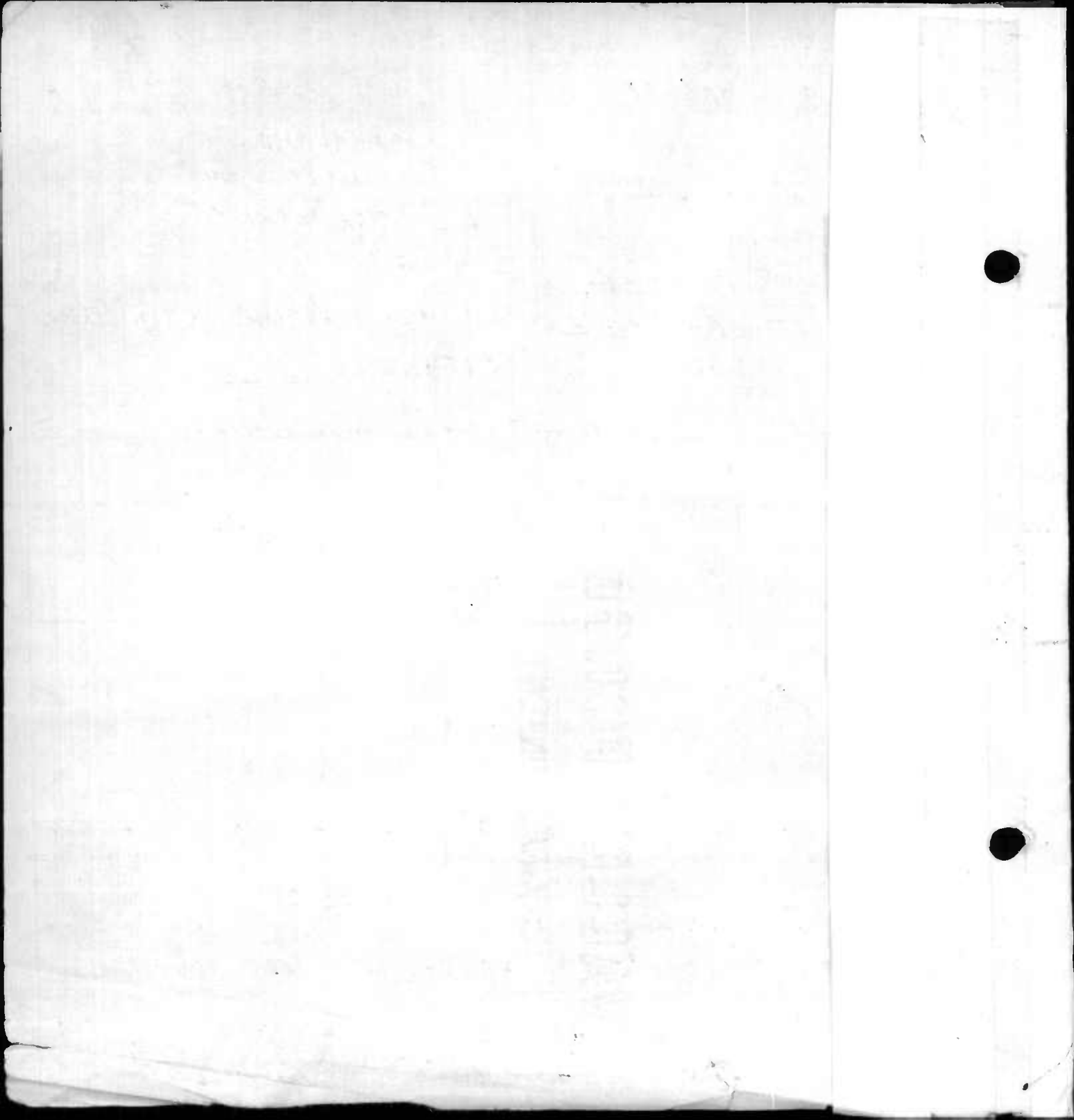
25B. NAME OF REGISTRAR

Robert E. Seaburn

25C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home
Phonix H. Miller (310) Franklin Ave

ADDRESS



5-120

66 09003

BALTIMORE CITY HEALTH DEPARTMENT

66 09003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT W. SEVICK

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1966 6:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2042 E. Biddle Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

10-25-1899

9. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AUTO MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

AUTO BVS.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.-A.

13. FATHER'S NAME

JAMES SEVICK

14. MOTHER'S MAIDEN NAME

ANNA -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-01-4757

17. INFORMANT

Mrs. Clara M. Sevick - 2042 E. Biddle St.

ADDRESS

18.

E481X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Gunshot wound of abdomen

(A) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

store

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

835 N. Gay Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

Sept. 4, 1966 5:25 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Visiting niece who is an employee and shot by one of two holdup men.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1966

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

9-9-66

23C. NAME of CEMETERY or CREMATORY

BALTIMORE CEM.

23D. LOCATION (City, town, or county) (State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1966

24B. NAME OF REGISTRAR

Robert E. Sevick

24C. FUNERAL DIRECTOR

Stanley Miller - 2334 Jefferson St.

ADDRESS

BURIAL 9-9-66 BATHING CEM. BALTO. MD.

John, wife - 2224

No. 10 - 10-28-1999
MARRIED
10-28-1999
U.S.A.
John -
John -
John -

66 09004

BALTIMORE CITY HEALTH DEPARTMENT

66 09004

BIRTH NO. 66-07396

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Alisa Clark

2. DATE AND HOUR PRONOUNCED DEAD

Sept. 4 1966

8:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1652 Warwick Ave.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 30 1966

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Single

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Clark

14. MOTHER'S MAIDEN NAME

#Juanita Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

David Clark 1652 Warwick Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Interstitial Pneumonitis (SDII)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐ACTUAL
SIGNATURE

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
Sept. 4. 196623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 9, 1966

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county)

Balto.

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1966

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 3197 Schomberg St

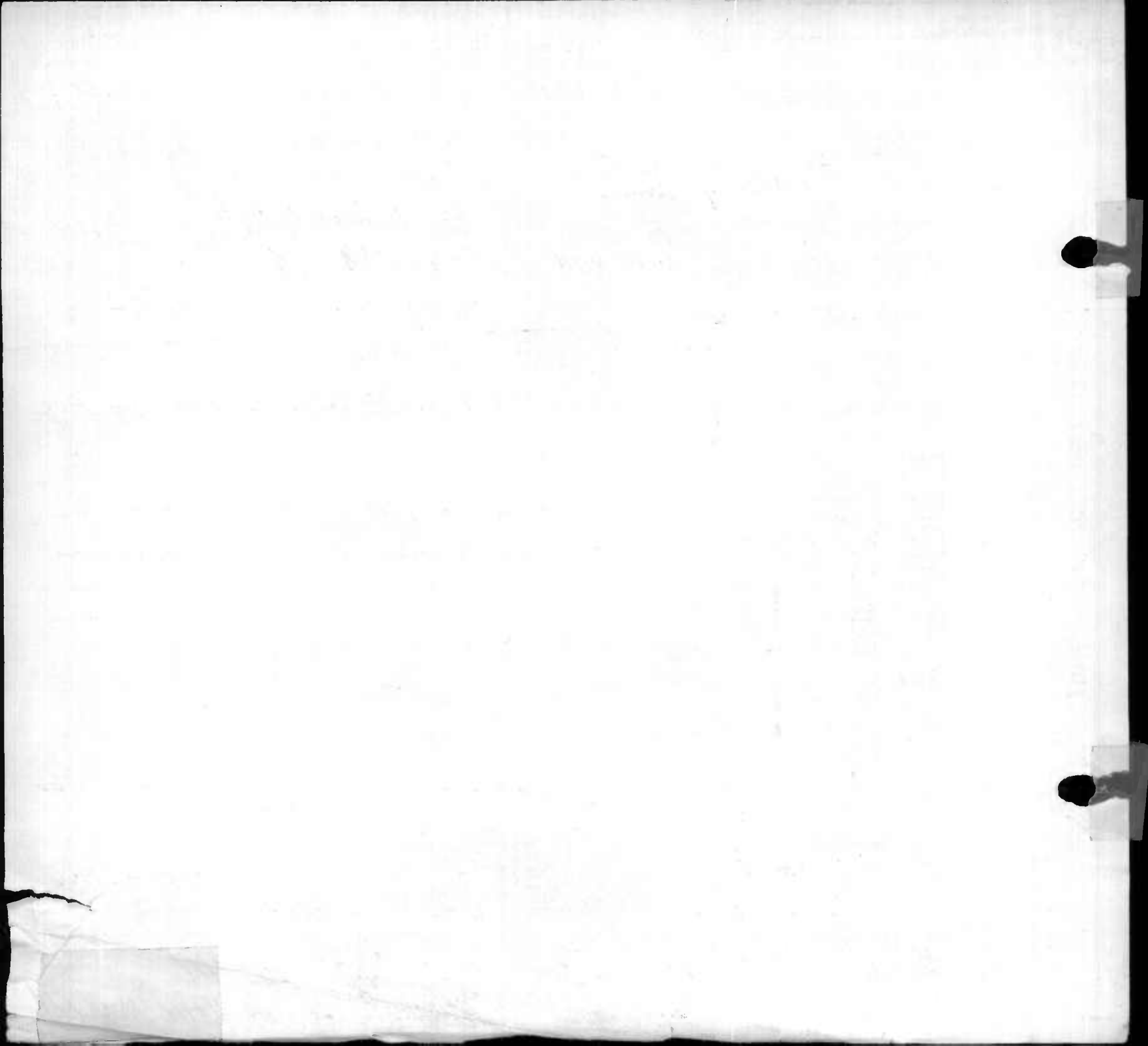
ADDRESS

WALL EX FORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09005 | |
|---|-------------------------|--|--------------------------------------|---|---|
| BIRTH NO. 66 09005 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Charles Shaw | | 2. DATE AND HOUR OF DEATH 9-4-66 12:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Nursing Home | | D. STREET ADDRESS (If rural, give location) 3639 Liberty Hgts. | | E. STREET ADDRESS (If rural, give location) | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 10-6-1888 | 9. AGE (In years, last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Charles Shaw | | 14. MOTHER'S MAIDEN NAME SARAH ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 212-16-6705 | | 17. INFORMANT Chart # 722 | |
| 18. 443X1 | | CAUSE OF DEATH | | ADDRESS 607 Penna Ave. | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gangrene of Rt. Foot (infected) | | (B) DUE TO | | 3 months | |
| | | (C) Gen. Arteriosclerosis | | Unknown | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Card.-Vasc. Disease | | Unknown | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from June 16 19 65 to Sept. 4 19 66 , that (I) (we) last saw the deceased alive on Sept. 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE E. E. Holt | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 4, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) E. E. Holt | | 23D. ADDRESS 3715 Liberty Hgts. Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY St. Matthews Cem. | |
| 24D. LOCATION (City, town, or county) West River Md. | | 24E. NAME OF REGISTRAR Robert E. Fairbank | | 24F. FUNERAL DIRECTOR Williams Funeral Home | |
| 24G. ADDRESS 3719 Schroeder St. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |



66 09006

BALTIMORE CITY HEALTH DEPARTMENT

66 09006

BIRTH NO. *Cleveland, Ohio*

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LATANYA

RIVERS c

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1966

10:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2309 Chelsa Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2309 Chelsa Terrace

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

S

8. DATE OF BIRTH

May 13, 1965

9. AGE (In years
lost birthday)

15 mths.

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cleveland Ohio

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Rivers

14. MOTHER'S MAIDEN NAME

Anetta Morrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Anetta Rivers 2309 Chelsa Terr.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~Stroke~~Mongolism with associated congenital
heart disease and recurrent respiratory
infection.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/8/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto. Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

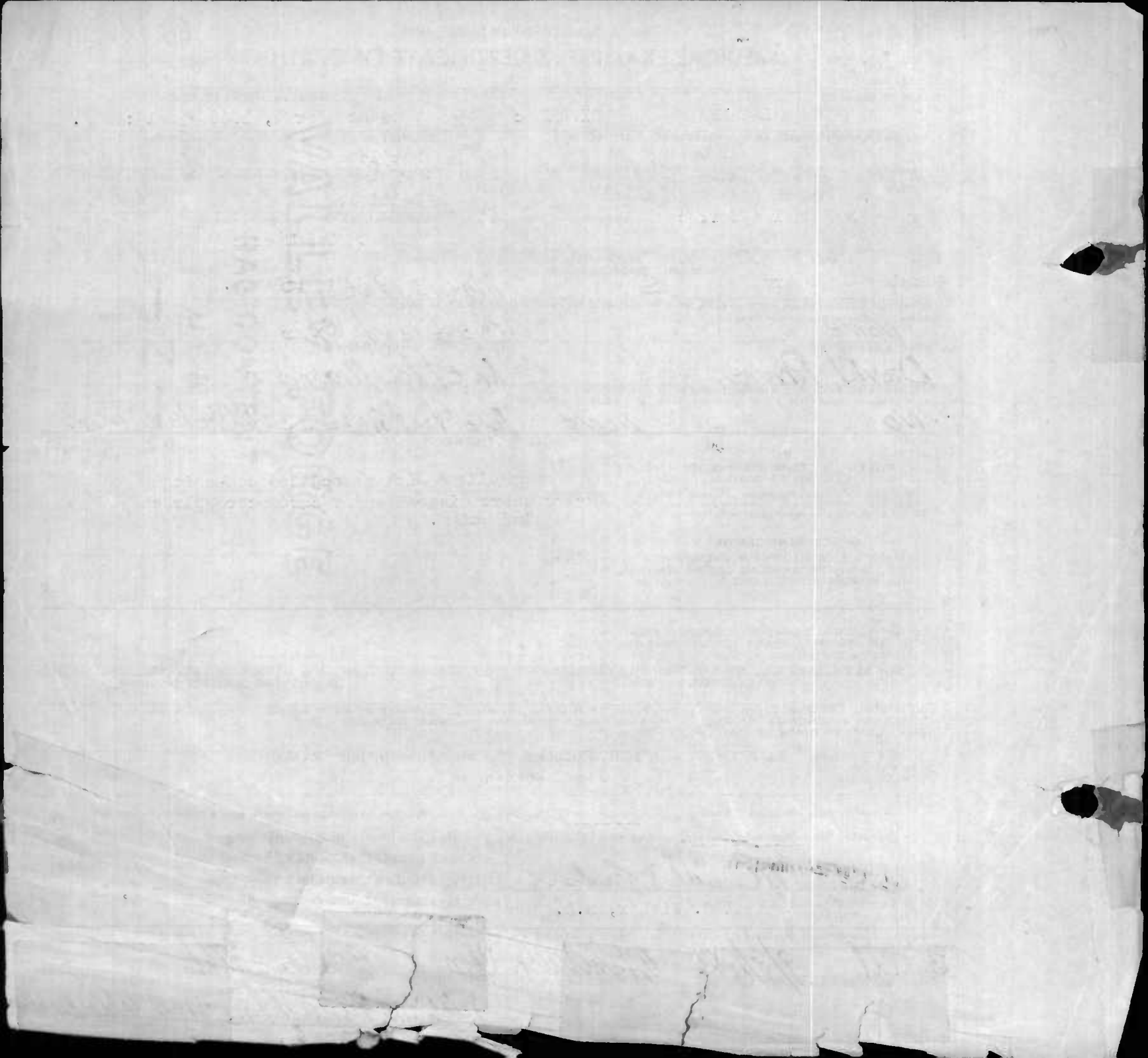
SEP 7 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Williams Funeral Home 319 N. Schwardt St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09007 | |
|---|---------------|--|---------------------------|---|--|
| BIRTH NO. 66 09007 | | CERTIFICATE OF DEATH | | Registered No. 66 09007 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Arthur Brown | | 2. DATE AND HOUR OF DEATH Sept 4, 1966 1 17:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md. Balto. City | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 18-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | D. STREET ADDRESS (If rural, give location) 1029 Sarah Ann St 21223 | | | |
| 5. SEX M | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 12-25-06 | 9. AGE (In years last birthday) 59 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Lodge Brown | | 14. MOTHER'S MAIDEN NAME Nexi Brown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 224-12-3900 | | 17. INFORMANT Hosp. Chart | |
| 18. 450.01 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (A) Cardiac Arrest | | 0 | |
| ANTECEDENT CAUSES | | (B) Congestive Heart Failure | | 2 wks | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Arteriosclerosis | | 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 No | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 Sept 1966 to 5 Sept 1966, that (I) (we) last saw the deceased alive on 5 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David E. Zickafoose M.D. | | | | 23B. DATE SIGNED 5 Sept 66 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID E. ZICKAFOOSE M.D. | | | | 23D. ADDRESS University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) Balto. Md. | | 24E. STATE (State) Md. | | 24F. ADDRESS | |
| 25A. DATE RECD. BY HEALTH DEPT. SEP 7 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Williams Funeral Home 3198 Schowdt St | |

2-11-1914

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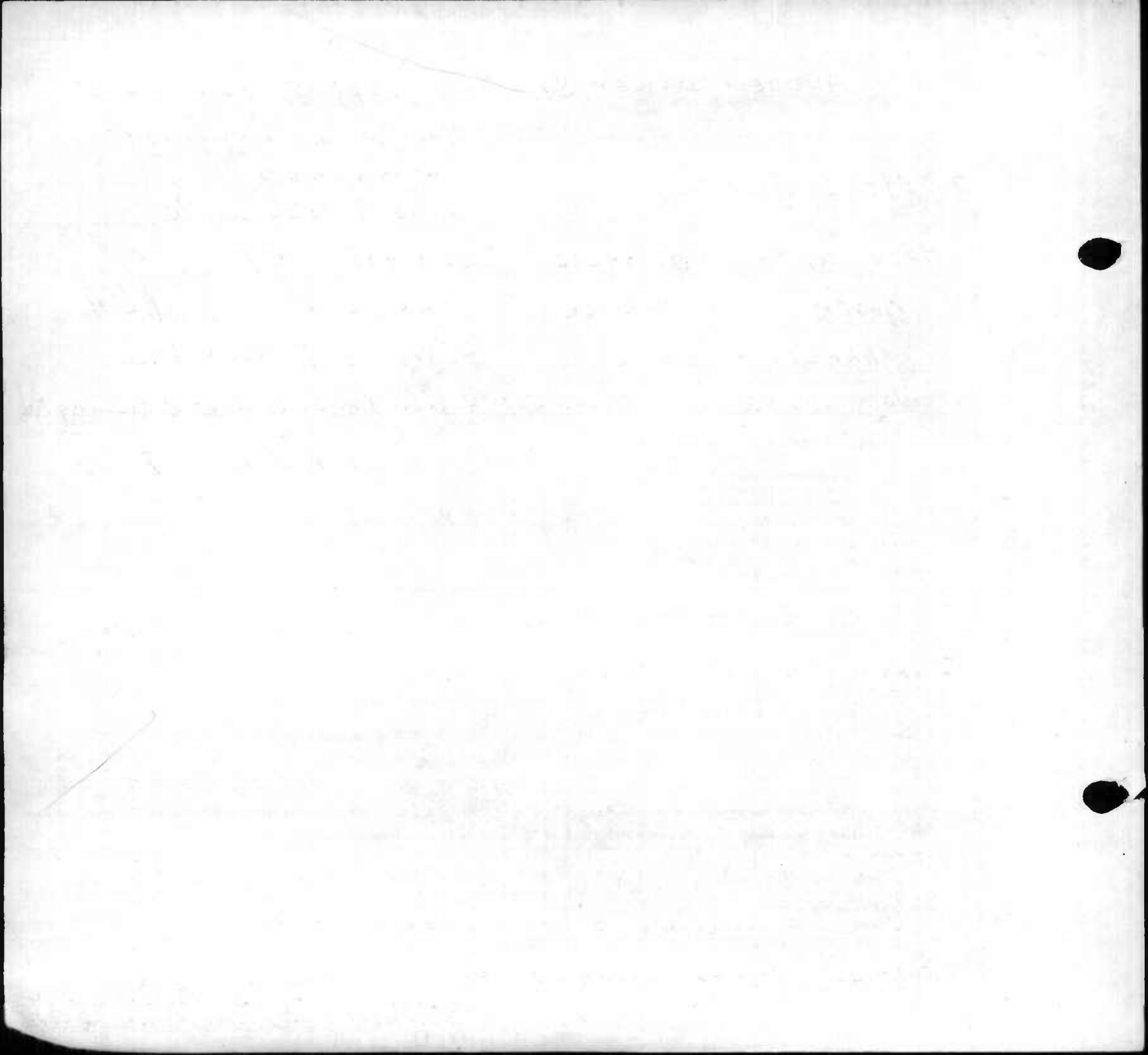
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09008 | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. 66 09008 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ANDREW DAILEY, JR. | | 2. DATE AND HOUR OF DEATH SEPT 5, 1966 6 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODLAWN 53700 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2100 N. ROLLING RD | | | |
| 5. SEX MALE | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH DEC. 1, 1908 | 9. AGE (In years lost birthday) 57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOVER | | 10B. KIND OF BUSINESS OR INDUSTRY TRANSFER | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME CHARLES P. DAILEY | | 14. MOTHER'S MAIDEN NAME FLORENCE I. KESMODEL | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-30-6527 | | 17. INFORMANT ADDRESS Andrew Dailey Jr 2100 N. Rolling Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION | | CAUSE OF DEATH (A) DUE TO ASCVD. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 7 days. | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHR. BRONCHITIS, EMPHYSEMA | | 15 years. | | | |
| 19A. DATE OF OPERATION TRACHEOTOMY | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - ASSIST BREATHE | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 30 1966 to SEPT 5 1966 , that (I) (we) last saw the deceased alive on SEPT 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James A. Quinlan, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 6, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES A. QUINLAN, JR. | | 23D. ADDRESS MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK | |
| 24D. LOCATION WOODLAWN Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | |
| 25B. NAME OF REGISTRAR George E. Schrab | | 25C. FUNERAL DIRECTOR George E. Schrab Funeral Home | | | |



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66 09009

BALTIMORE CITY HEALTH DEPARTMENT

66 09009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 32-61-51

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ernest Smullen

2. DATE AND HOUR PRONOUNCED DEAD

7-29-66 6:30 P.M.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University of Maryland
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Wicomico

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Salisbury

D. STREET ADDRESS (If rural, give location)

237 Ohio Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-31-31

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Roofer

10B. KIND OF BUSINESS OR INDUSTRY

Roofing

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?
U S A

13. FATHER'S NAME

Dewey Smullen

14. MOTHER'S MAIDEN NAME

Hattie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-24-4838

17. INFORMANT

Mrs. Carol Smullen

ADDRESS

237 Ohio Ave., Salisbury, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Metastatic melanoma to brain

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Melanoma of posterior chest

5 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

7-19-66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Brain tumor.

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Building

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Salisbury, Md.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
10-31-61

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Contused black mole of back at work.

22.

I certify that I held an Inquiry ☒ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Earl L. Royer, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-30-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-2-66

23C. NAME OF CEMETERY or CREMATORY

Wicomico Memorial Park Salisbury, Wicomico, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 7 1966

24B. NAME OF REGISTRAR

Robert E. Salisbury

24C. FUNERAL DIRECTOR

ADDRESS

Hollowy & Company, Salisbury, Md.

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66 09010

BALTIMORE CITY HEALTH DEPARTMENT

66 09010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **MARSHALL JACKSON** 2. DATE AND HOUR PRONOUNCED DEAD **September 5, 1966 3:40 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Provident Hospital** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

STREET ADDRESS (If rural, give location) **1538 Mc Kean Avenue**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **1-15-1944** 9. AGE (In years last birthday) **22** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Stock Clerk** 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Baltimore, Md** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Robert L. Jackson** 14. MOTHER'S MAIDEN NAME **Eleanor Kruse**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT **Nancy Jackson-1538 Mc Kean Ave.** ADDRESS

18. CAUSE OF DEATH **Interstitial myocarditis** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Russell S. Fisher** M.D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **September 5, 1966**

EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **9-8-66** 23C. NAME OF CEMETERY OR CREMATORY **Mt. Auburn** 23D. LOCATION (City, town, or county) (State) **Baltimore Md**

24A. DATE REC'D BY HEALTH DEPT. **SEP 7 1966** 24B. NAME OF REGISTRAR **Robert E. Talbot** 24C. FUNERAL DIRECTOR **Purnell S. Oden - Balto. Md.** ADDRESS

VS 151-REV. 1/1/65

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1-15-1941
Baltimore, Md. 2124
Thurs. Evn.
Maryland - 1738 Mc K.

Maryland

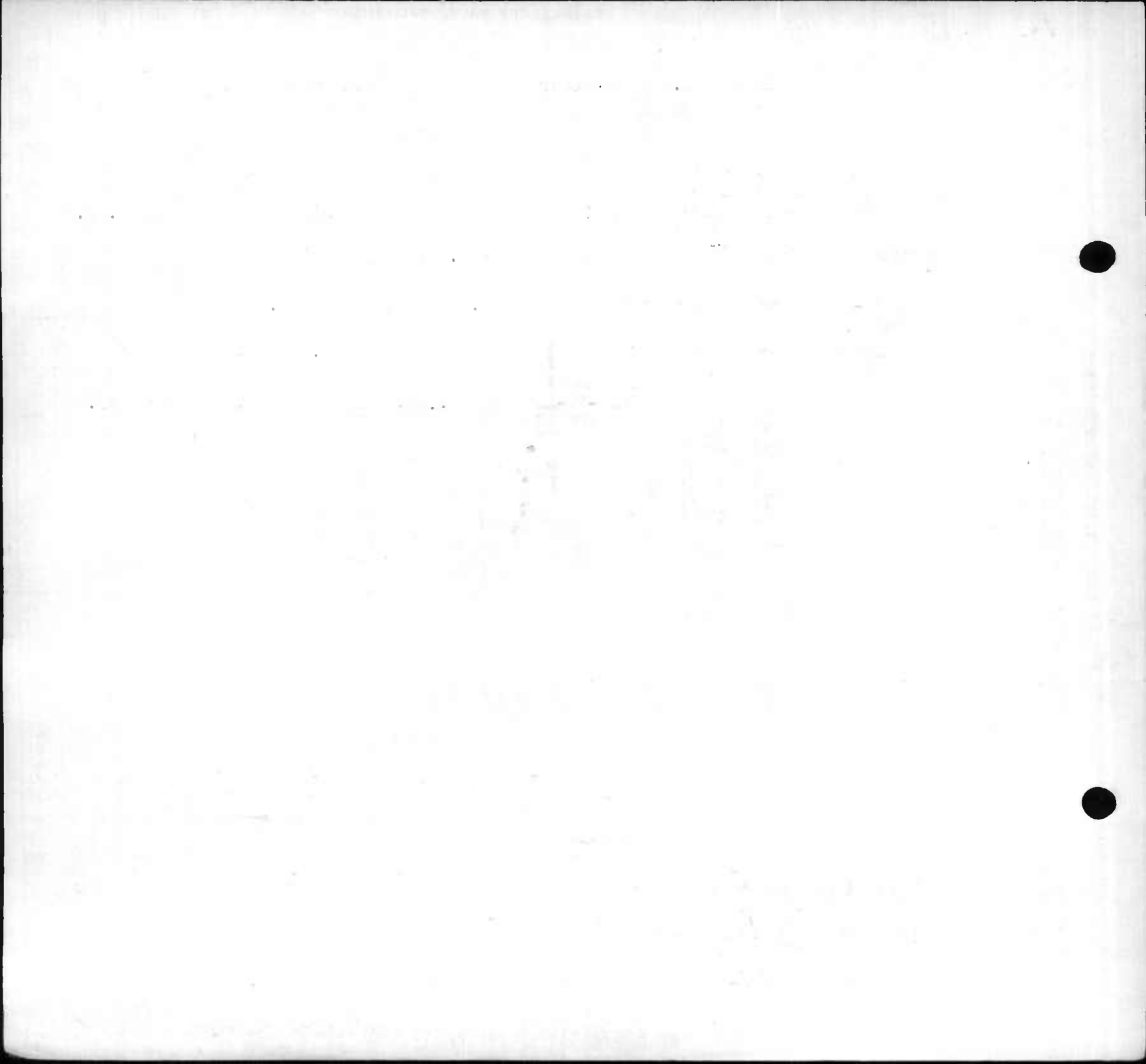
Robert L. Jackson
1738 Mc K.

Baltimore, Md.
1-15-1941
Thurs. Evn.
Maryland - 1738 Mc K.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

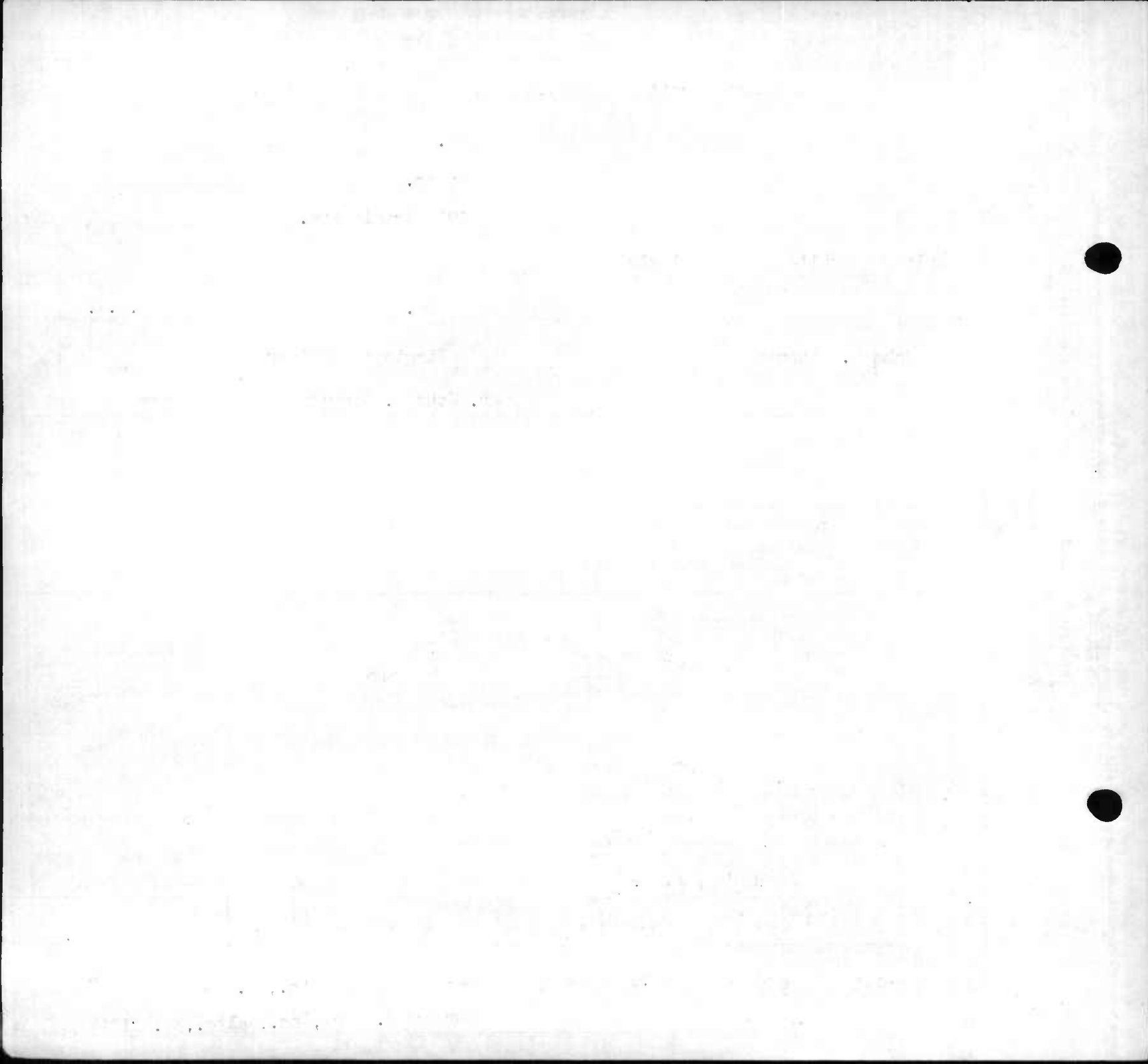
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09011 | |
|---|---|--|---|---|---|
| 66 09011 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09011 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Clara A. McCusker | | | 2. DATE AND HOUR OF DEATH September 5, 1966 2³⁰ P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Midtown Nursing Home 808 Saint Paul Street Baltimore, Maryland 21202 | | | A. STATE Maryland | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 808 Saint Paul Street Midtown N. H. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH Jan. 6, 1883 | 9. AGE (In years last birthday) 83 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Armstrong Linoleum Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Louis McCusker | | | 14. MOTHER'S MAIDEN NAME Mary A. ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-22-6627 | | 17. INFORMANT ADDRESS Mrs. Ed. Cullen 503 E. Seminary Ave. | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO Cardio-Respiratory Failure (B) DUE TO Uremia (C) DUE TO Art. C. V. H.D. Gen. Arteriosclerosis Sclerosis | | |
| | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 5 1964 to Sept 5 1966 , that (I) (we) last saw the deceased alive on Sept 5 1966 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) William D. Applefeld | | | | 23D. ADDRESS 5507 PK Hgts Dr | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/7/1966 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR Wm. J. Tichner Sons | |
| | | | | ADDRESS Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

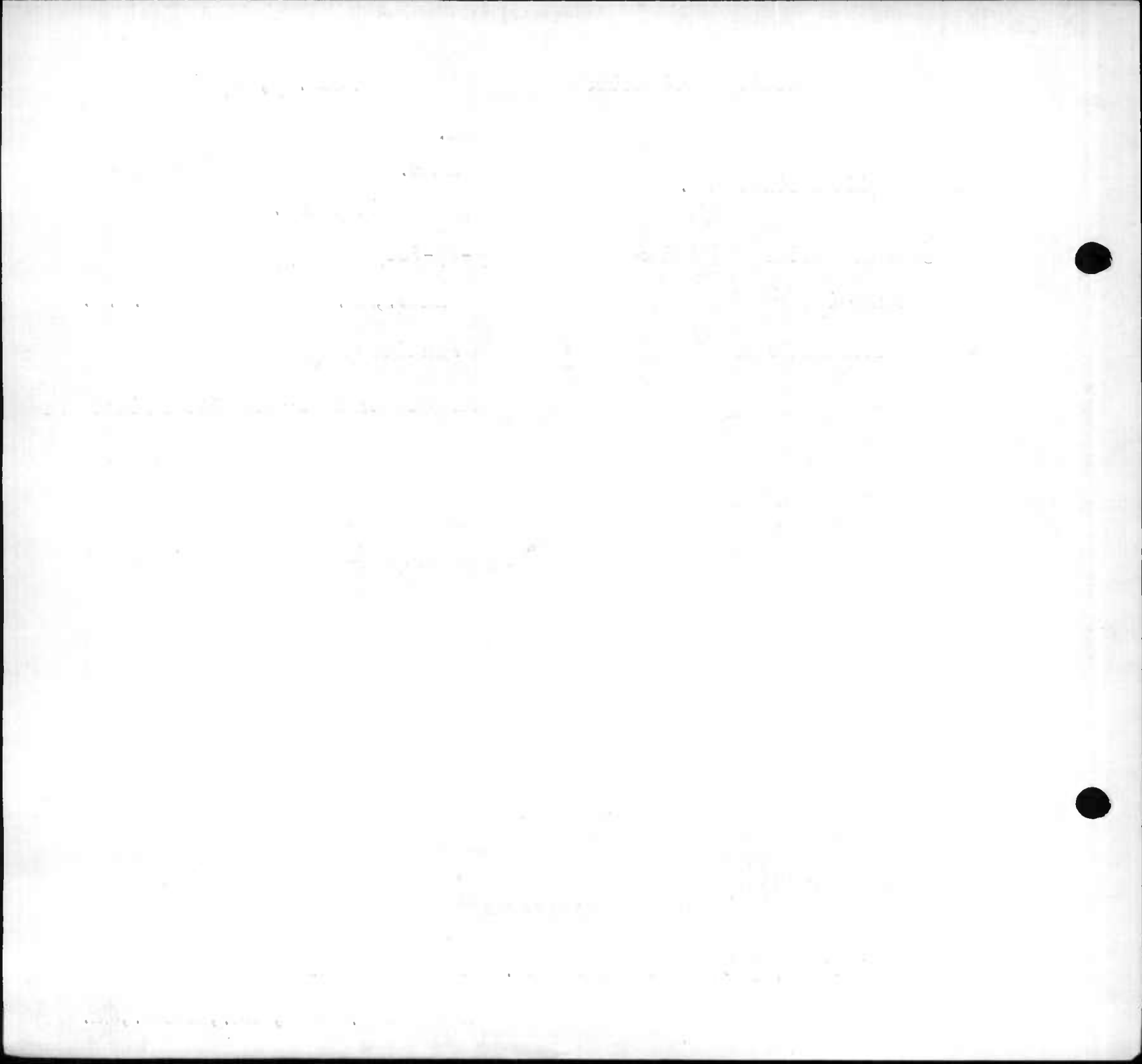
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|--|-------------------------|--|-----------------------------------|---|--|
| 66-14724 66 09012 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09012 | |
| BIRTH NO. 66 09012 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9-6-66 1 1⁴⁵ P M. | |
| 1. NAME OF DECEASED (Type or Print) Matthew Scott Chapman | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-03 D. STREET ADDRESS (If rural, give location) 5006 Arabia Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 9-3-66 | 9. AGE (In years last birthday) 3 | If Under 1 Yr. Months: Days: Hours: Min. 3 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John N. Chapman | | | |
| 14. MOTHER'S MAIDEN NAME Virginia Riddicord | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. John N. Chapman | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Hemorrhage Thrombocytopenia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Sepmatinity | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-3-1966 to 9-6-1966 , that (1) (we) last saw the deceased alive on 9-6-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Perry S. Shelton M.D. | | | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) Perry S. Shelton M.D. | | | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/7/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

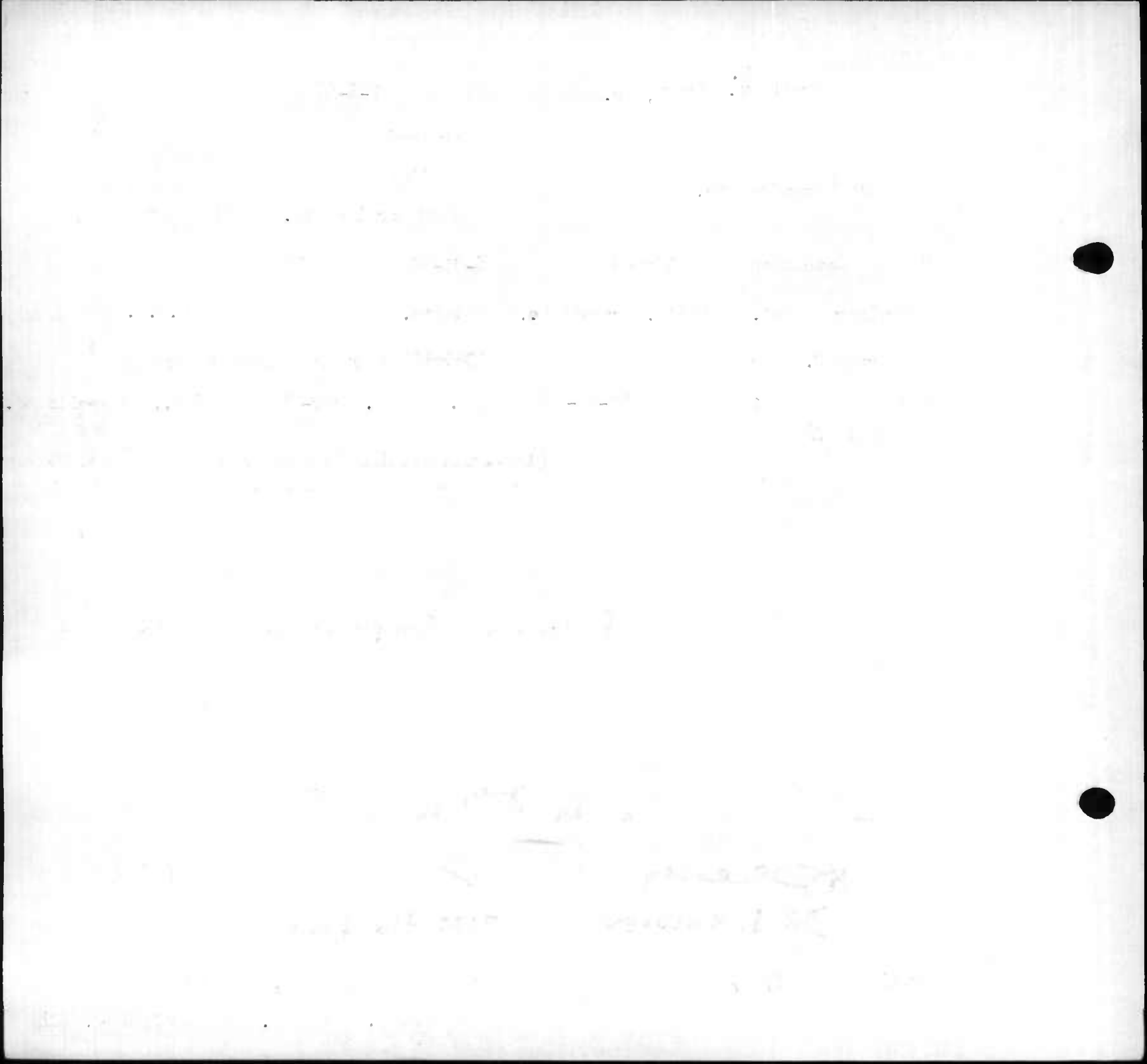
| | | | | | |
|---|-------------------------|--|--------------------------------------|--|---|
| BIRTH NO. 66 09013 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09013 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Annie Liedlich | | 2. DATE AND HOUR OF DEATH Sept. 5, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4226 Seidel Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 4226 Seidel Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 7-19-1887 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months: Days: Hours: Min. 1 day 7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | |
| 13. FATHER'S NAME Clarence Noel | | 14. MOTHER'S MAIDEN NAME Pauline Craft | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Margaret Bowers 4226 Seidel Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4226 I Coronary Embolism Hypertensive Cerebral Aneurysm | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 10-6-61 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 10 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-4-1937 to 9-5-1966 , that (I) (we) last saw the deceased alive on 8-31-66 and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. J. Grossfeld | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) MICHAEL J. GROSSFELD, M.D. | | 23D. ADDRESS 5402 Belair Road, Baltimore, Md. 21206 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/5/66 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | 25B. NAME OF REGISTRAR John E. Johnson | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09014 | |
|--|--------------------------|--|---------------------------------|--|---|
| BIRTH NO. 66 09014 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9-6-66 M. | | | |
| 1. NAME OF DECEASED (Type or Print) Frank C. Pahr, Sr. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2919 Harview Ave. | | A. STATE Maryland B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2919 Harview Ave. | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-31-92 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. | | 11. BIRTHPLACE (State or foreign country) Balto. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frank C. Pahr | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1 | | 16. SOCIAL SECURITY NO. 213-05-9812 | | 17. INFORMANT ADDRESS Mr. John R. Pahr- 108 Boyd Dr., Annapolis Md. | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 12 yrs + | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Embolism | | | | 12 yrs + | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1954 to 9-6-66 , that (I) (we) last saw the deceased alive on 8-29-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 9.6.66 | |
| 23C. PHYSICIAN'S NAME (Type) DR J. SKLOVEN | | | | 23D. ADDRESS 7122 Harford Rd | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. #14 | |



1
S-530

66 09015

BALTIMORE CITY HEALTH DEPARTMENT

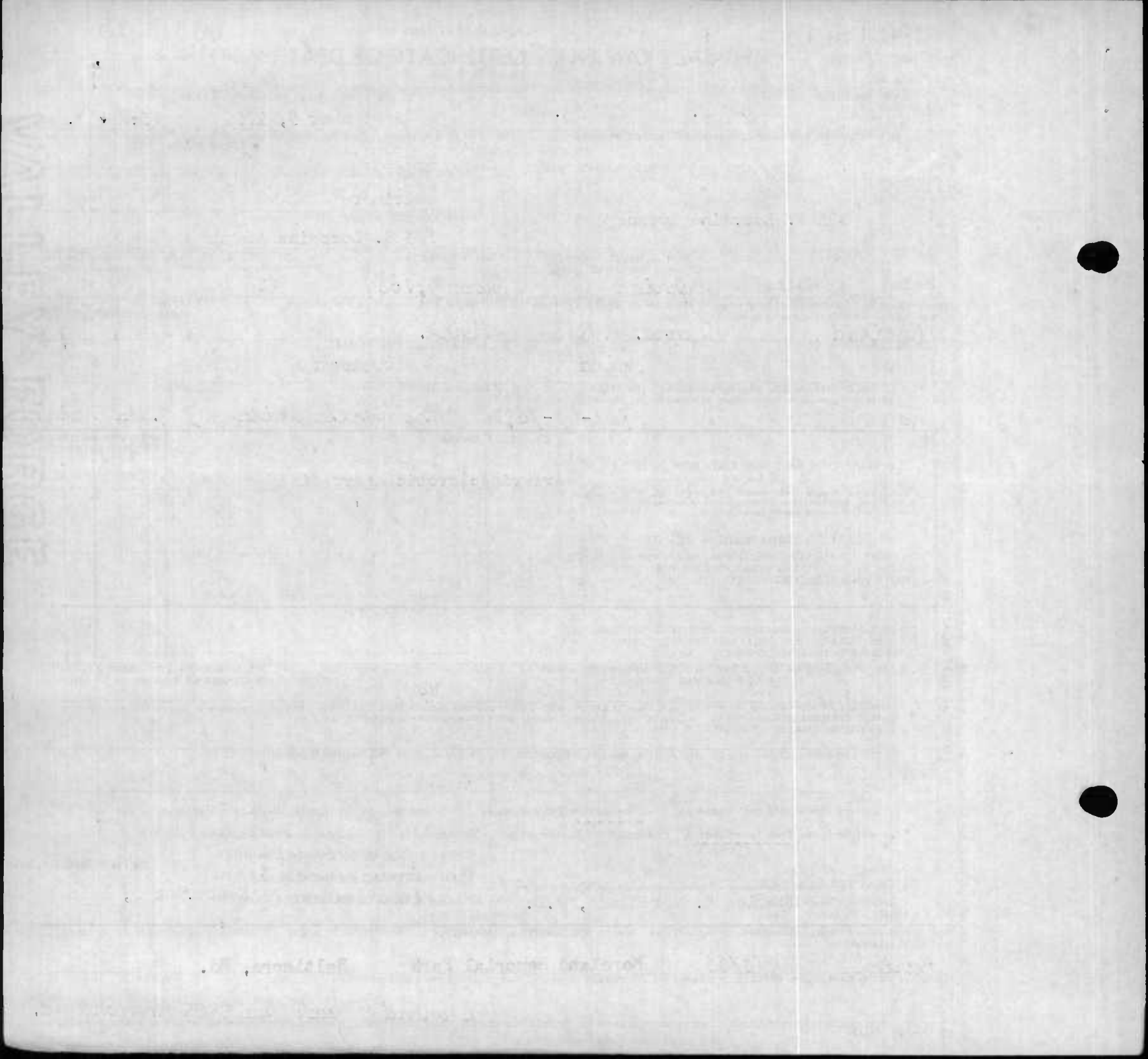
66 09015

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

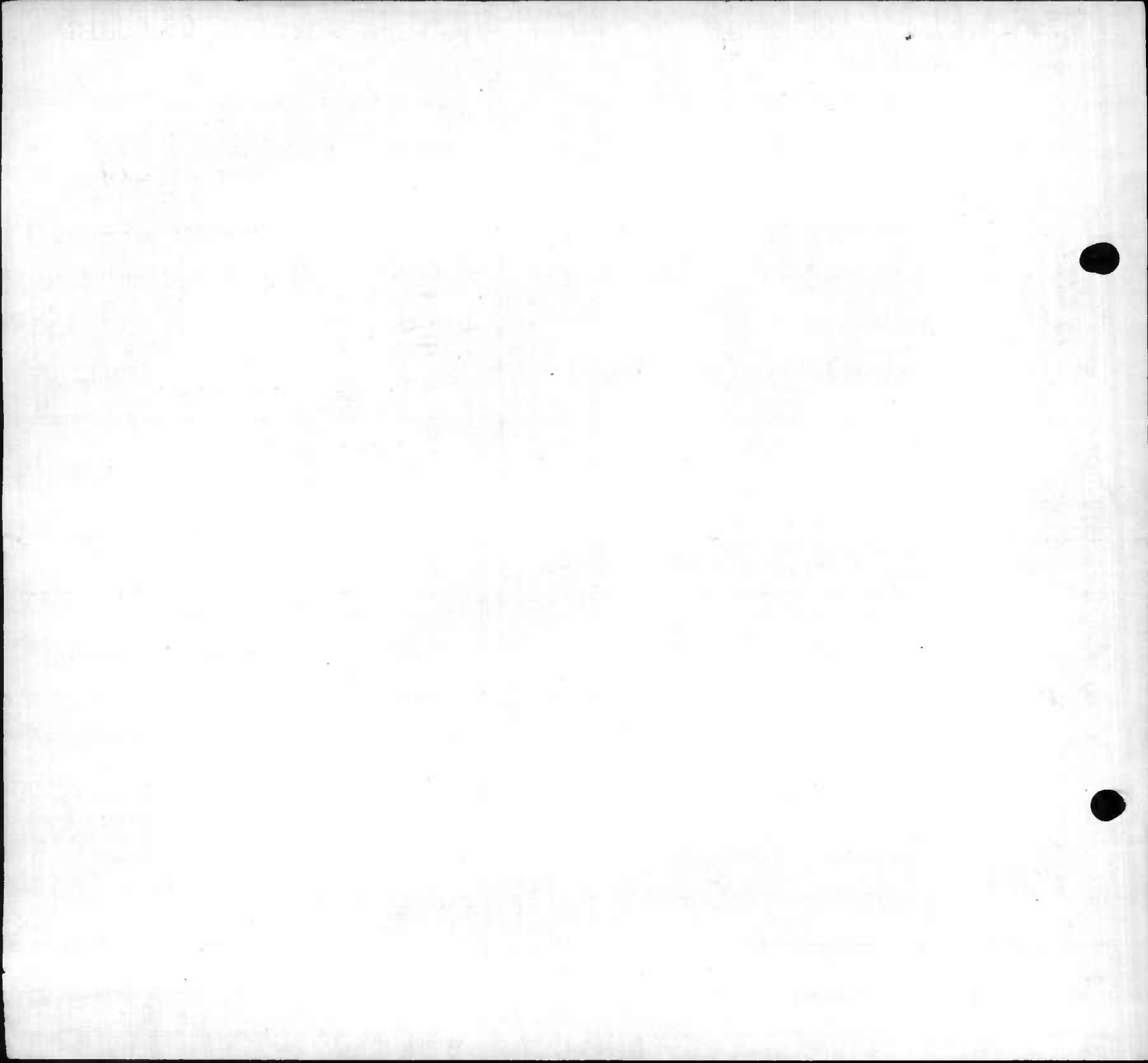
| | | | |
|---|-------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) CHARLES E. SMITH SR. | | 2. DATE AND HOUR PRONOUNCED DEAD September 5, 1966 5:28 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 305 E. Lorraine Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-03 D. STREET ADDRESS (If rural, give location) 305 E. Lorraine Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 5, 1884 |
| 9. AGE (In years last birthday) 82 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Penna. R R | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Smith | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 717-07-7892 | |
| 17. INFORMANT Mrs Myrtle Smith | | ADDRESS 305 E. Lorraine | |
| 18. CAUSE OF DEATH 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 5, 1966 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/8/66 | |
| 23C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | | 23D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| 24C. FUNERAL DIRECTOR Leonard J Ruck Inc | | ADDRESS 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|-----------|--|--|---------------------------|---|--|---|--|---------|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09016 | | | | | | | | | |
| BIRTH NO. 66 09016 | | | | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) SCHMITT, HELENE E. | | | | | 2. DATE AND HOUR OF DEATH 9/6/66 9:05 AM M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS | | | | | A. STATE Md B. COUNTY Baltimore | | | | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-01 | | | | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3804 MORAVIA AVE | | | | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 04-09-13 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE CLERK | | | 10B. KIND OF BUSINESS OR INDUSTRY C & P Telephone Co. | | 11. BIRTHPLACE (State or foreign country) Md. Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME HARRY PHOEBUS | | | | | 14. MOTHER'S MAIDEN NAME JOZ WIAK EVA | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - | | | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT George E. Schmitt, husband, above CHART - PATIENT | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH (A) DUE TO Ca BREAST | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | | | | |
| | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NO | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/29/66 1966 to 9/6 1966, that (I) (we) last saw the deceased alive on 9/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Melvin H. Epstein M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9/6/66 | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) MELVIN H. EPSTEIN M.D. | | | | | 23D. ADDRESS 550 N. BROADWAY BALTIMORE, MD. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------|---|------------------------------------|--|--|
| BIRTH NO. 66 09017 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09017 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 08 | |
| 1. NAME OF DECEASED (Type or Print) Miller, Michael | | 2. DATE AND HOUR OF DEATH 9-3-66 5P | | M. 08 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours | | A. STATE Md. B. COUNTY Balto. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 618 N. Glover Street | | | |
| 5. SEX M | 6. RACE O. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M. | 8. DATE OF BIRTH 3-18-08 | 9. AGE (In years last birthday) 58 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bracer | | 10B. KIND OF BUSINESS OR INDUSTRY Not in Can Co. | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Miller | | 14. MOTHER'S MAIDEN NAME FRANCES Nowicki | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-01-9263 | | 17. INFORMANT ADDRESS Gertrude Bessling Miller, wife, above | |
| 18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART DISEASE DUE TO (B) CONGESTIVE HEART FAILURE DUE TO (C) HYPERNEPHROMA OF LEFT KIDNEY | | INTERVAL BETWEEN ONSET AND DEATH MONTHS MONTHS — | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21E. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 8-23-66 19 66 to 9-3 19 66 , that (1) (we) last saw the deceased alive on 9-3-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Agustin del Campo | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-3-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/7/66 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | |
| 25B. NAME OF REGISTRAR Alfred E. Fabry | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 2601 E. Madison St. | |

618 N. Clark Street
3-18-08

1828

Francis

Walter D. Baker

John Miller

9-25-08

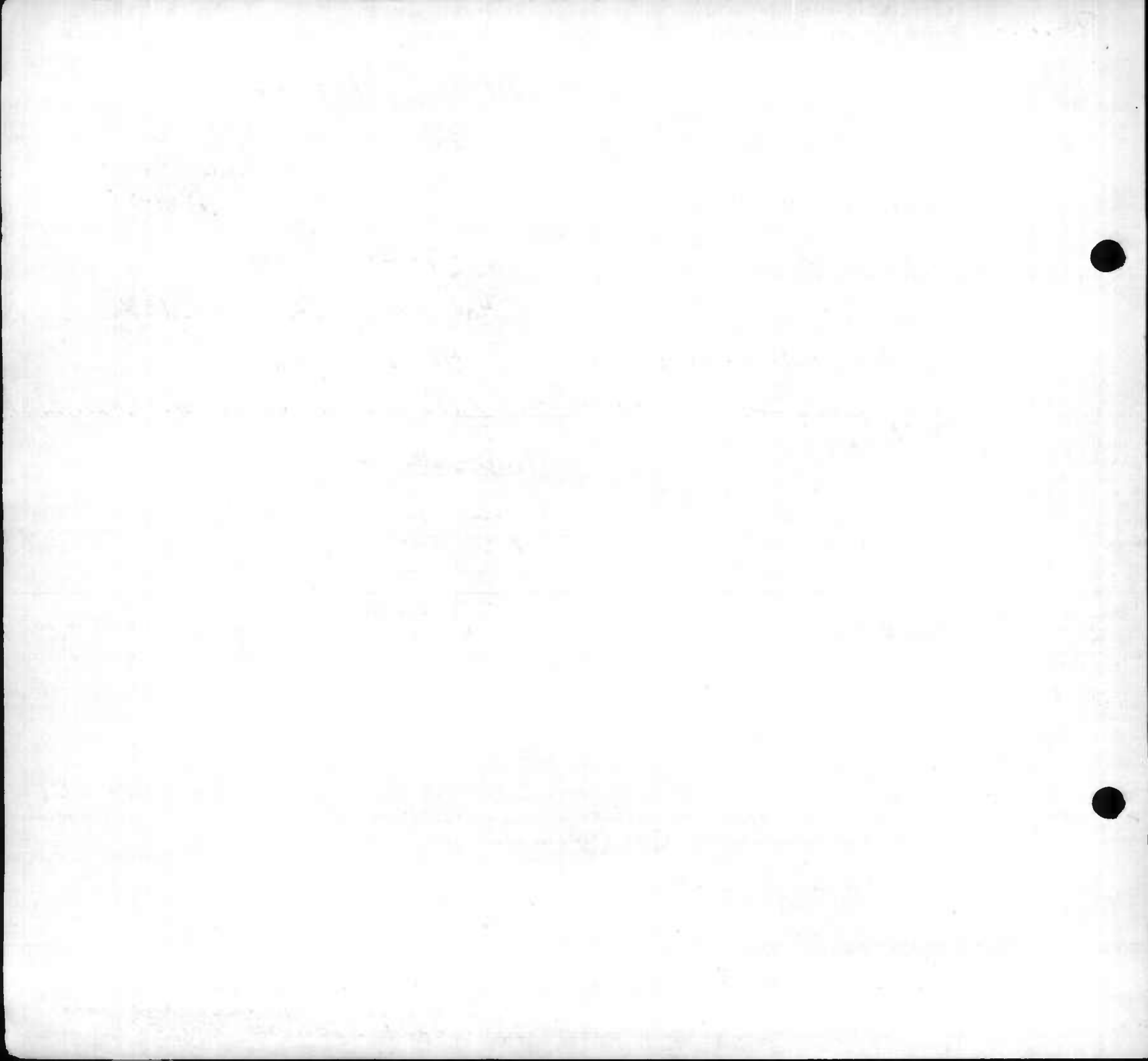
Capitol City Camp

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 66 09018 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 09018 | | | | |
| 1. NAME OF DECEASED (Type or Print) RESIDE, JOHN PARK JR | | | | | | | | | | 2. DATE AND HOUR OF DEATH 9-3-66 19:45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY Hosp. | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE BALTIMORE B. COUNTY - 21205 MARYLAND | | | | |
| 5. SEX M 6. RACE W 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | | | | | | | 8. DATE OF BIRTH 12-7-21 9. AGE (In years last birthday) 44 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY MINISTER | | | | | 11. BIRTHPLACE (State or foreign country) HARRISBURG PA. | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | | | | | | | | | 13. FATHER'S NAME JOHN PARK RESIDE SR. | | | | |
| 14. MOTHER'S MAIDEN NAME ALICE MYERS. | | | | | | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES, WWII | | | | |
| 16. SOCIAL SECURITY NO. 171-20-844 | | | | | | | | | | 17. INFORMANT RUTH EILEEN RESIDE 2433 E. MADISON ST. ADDRESS | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) ACUTE MYOCARDIAL INFARCTION 3 WEEKS (B) CORONARY ARTERY SCLEROSIS & OCCLUSION. (C) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MALIGNANT HYPERTENSION, & NECROTIZING ARTERIOCLITIS, 4/63 | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/1963 19 to 9/3 19 66 , that (I) (we) last saw the deceased alive on 9/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Francis J. Borges M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Type) FRANCIS J. BORGES M.D. | | | | | | | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 9-6-66 | | | | | 24C. NAME OF CEMETERY OR CREMATORY HALIFAX CEM. | | | | |
| 24D. LOCATION (City, town, or county) HALIFAX PA. | | | | | 24E. STATE (State) PA. | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR SCHIMMELK FUNERAL HOME INC. 3331 BRENNES MANE. ADDRESS | | | | |

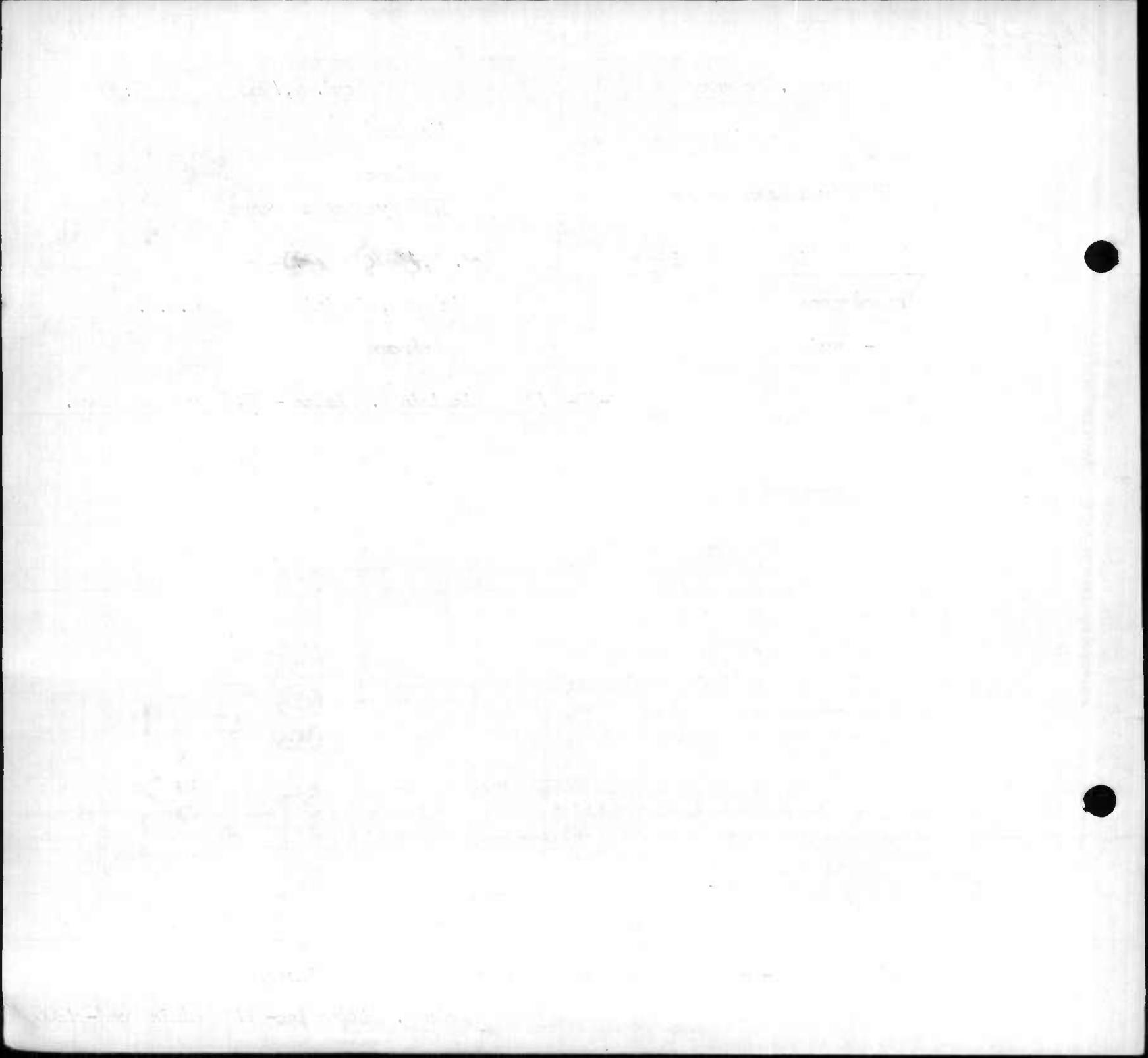
SEP 7 1966



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 09019 | |
|--|--|--|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> M-256 BIRTH NO. 66 09019 </div> | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mary L. McHenry </div> <div> 2. DATE AND HOUR OF DEATH Sept. 4, 1966 5:30 P M. </div> </div> | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 3705 Evergreen Avenue </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3705 Evergreen Avenue </div> </div> | | | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH Oct. 9, 1888 | |
| | | | | 9. AGE (In years last birthday) 77 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Richmond, Virginia | |
| 13. FATHER'S NAME - Davis | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 220-12-7812 | | 17. INFORMANT Virginia L. Fisher - 3705 Evergreen Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Arteriosclerotic cardiovascular - myocardial failure (B) 10 years (C) 10 days | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 2 19 57 to Sept 4 19 66 that (I) (we) last saw the deceased alive on Sept 4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 9/6/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. E. J. Alessi | | | | 23D. ADDRESS 6217 Harford Rd Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-7-66 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR John C. Miller Inc | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206 | | ADDRESS | |



1
M-260

BIRTH NO. 66 09020

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09020

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA Marie MEAGHER

2. DATE AND HOUR PRONOUNCED DEAD

September 5, 1966

12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2413 E. Oliver Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2413 E. Oliver Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Dec. 3, 1891

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

U.S.F. & G.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick J. Meagher

14. MOTHER'S MAIDEN NAME

Mary Leahy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-07-8005

17. INFORMANT

ADDRESS

Margaret Meagher - 2413 E. Oliver Street

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Charles S. Springgate, M.D.
NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-8-66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

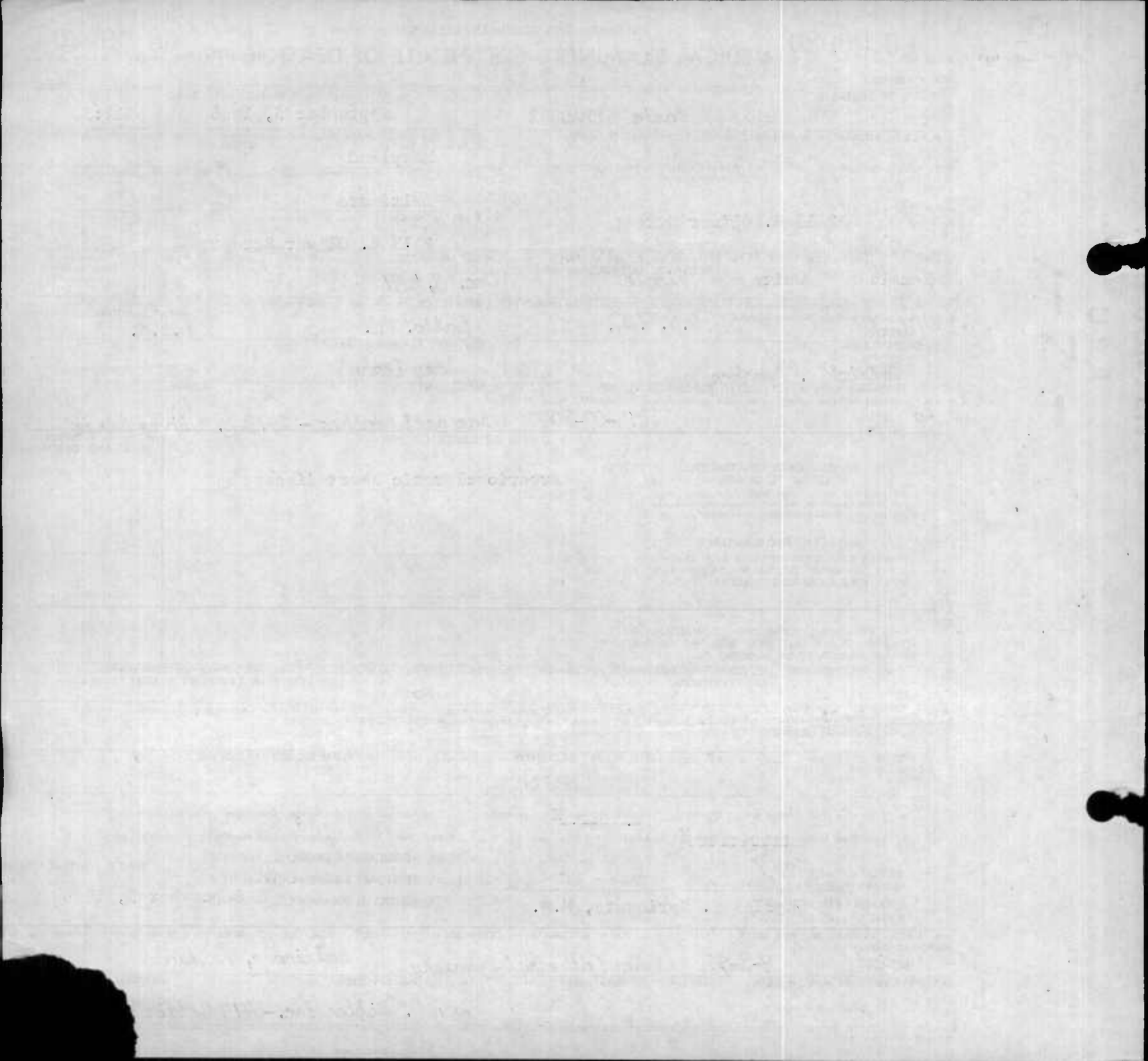
24C. FUNERAL DIRECTOR

ADDRESS

SEP 7 1966

John C. Miller Inc. - 6415 Belair

John C. Miller Inc. - 6415 Belair



41-53-26
NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 09021 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 09021 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Annie Tucker Rogers | | | | 2. DATE AND HOUR OF DEATH 6 Sept 1966 3:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue, Balto. Md. 21224 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 3033 Monclaire Ave 21216 | | | |
| 5. SEX F | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 5/27/93 | | 9. AGE (In years, lost birthday) 73-8-7 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | | | 11. BIRTHPLACE (State or foreign country) Wilmington, N.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Josh TUCKER | | | | 14. MOTHER'S MAIDEN NAME SUSAN TELFAIR | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. — | | | | 17. INFORMANT Chert. | | | | RECORDS: BCH, 4940 Eastern Avenue Baltimore, Md. 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331X I Respiratory Arrest | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Old CVA ; Decubiti | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 9/6 9/9 19 64 to 6 Sept 19 66 , that (H) (we) last saw the deceased alive on 6 Sept 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (diagnose) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE D. A. Raine Jr. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 6 Sept 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) D. A. Raine, Jr. | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Family Lot | | 24D. LOCATION (City, town, or county) (State) Wilmington, North Carolina | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | 25B. NAME OF REGISTRAR Herbert E. Nutter | | 25C. FUNERAL DIRECTOR HERBERT E. NUTTER | | ADDRESS 3035 W. North Ave | | | | | |

Amelanchier

8-11-82

232

Reorganized

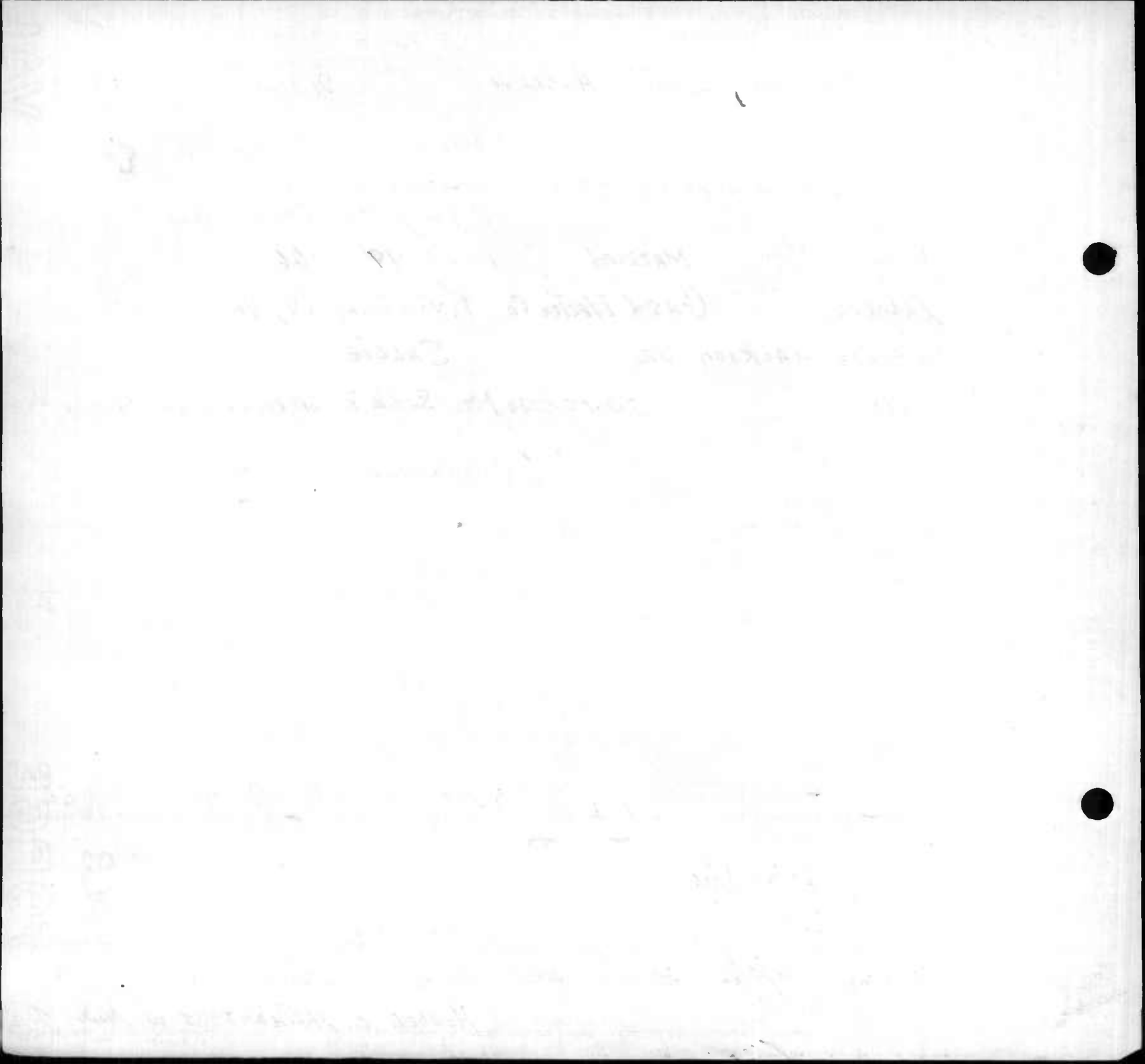
25

B. A. R. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|------------------------------|--|---------------------------------|
| BIRTH NO. 66 09022 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09022 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JACKSON, LESLIE Andrew | | 2. DATE AND HOUR OF DEATH 9/5/66 4: A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-41 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2946 Clifton Ave | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-23-99 | 9. AGE (In years) 66 | 10. If Under 1 Yr. Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co | | 11. BIRTHPLACE (State or foreign country) Knottaway Co, VA | |
| 13. FATHER'S NAME LESLIE JACKSON SR | | 14. MOTHER'S MAIDEN NAME SALLIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-05-5280 | | 17. INFORMANT Mrs. Sadie R. Jackson - 2946 Clifton Ave | |
| 18. 493X1 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Pneumonia | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 8/31/1966 to 9/5/1966, that (I) lost saw the deceased alive on 9/4/1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. R. Ggie | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/5/66 | |
| 23C. PHYSICIAN'S NAME (Type) I. R. Ggie | | 23D. ADDRESS M.D. Lutheran Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | 25B. NAME OF REGISTRAR Herbert E. Nutter | | 25C. FUNERAL DIRECTOR HERBERT E. NUTTER 3035 W. NORTH AVE | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|--|--|
| BIRTH NO. H-522 66 09023 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09023 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) ROSA MAE HANCOCK | | | 9-4-66 8:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | A. STATE Maryland B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, give RURAL and give township) Baltimore | | | D. STREET ADDRESS (If rural, give location) 1838 North Durham Street 21213 | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) Never Married | 8. DATE OF BIRTH 6-13-1931 | 9. AGE (In years last birthday) 35 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Private Family | | 11. BIRTHPLACE (State or foreign country) Virginia -(Charlotte Co) | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Marshall Hancock | | | |
| 14. MOTHER'S MAIDEN NAME Mollie L. Davis | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-32-9512 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 5-40.0 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hyperthyroidism | | | CAUSE OF DEATH (A) Anoxia DUE TO (B) Aspiration Pneumonitis DUE TO (C) Gastric Ulcer Sepsis | | |
| 19A. DATE OF OPERATION 9-3-66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Ulcer | | |
| 20A. AUTOPSY? (Yes or No) Yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) none | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> none | | 21F. HOW DID INJURY OCCUR? none | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-4 19 66 to 9-4 19 66 , that (I) (we) last saw the deceased alive on 9-4-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles B. Beckman | | | 23B. DATE SIGNED 9-4-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Charles B. Beckman | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. 6116 E. Pratt St. Baltimore Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Zion Baptist Cemetery | |
| 24D. LOCATION Charlotte County, Virginia | | 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | |
| 25B. NAME OF REGISTRAR Herbert E. Nutter | | 25C. FUNERAL DIRECTOR ADDRESS 3035 W. North Ave | | | |

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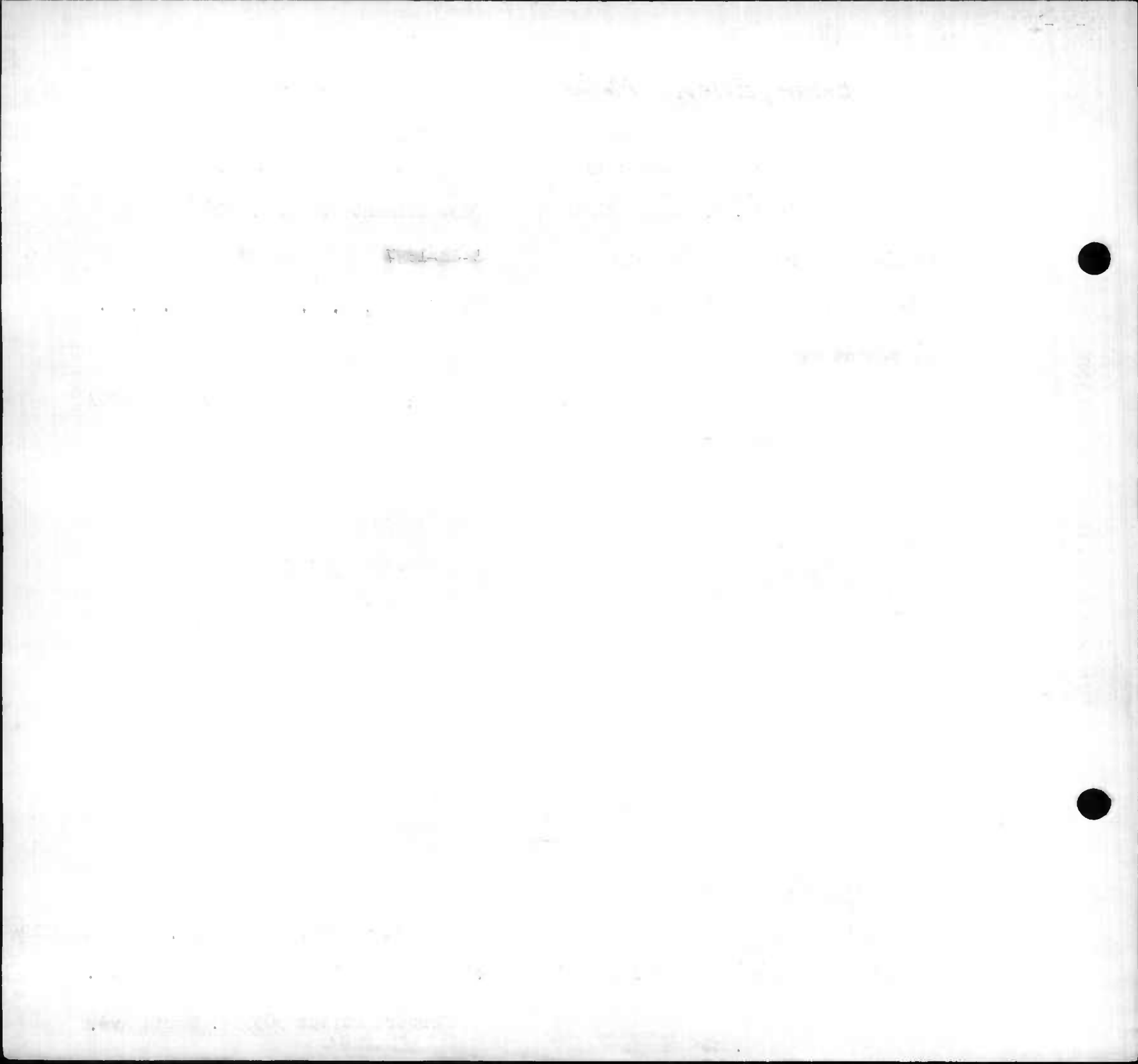
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

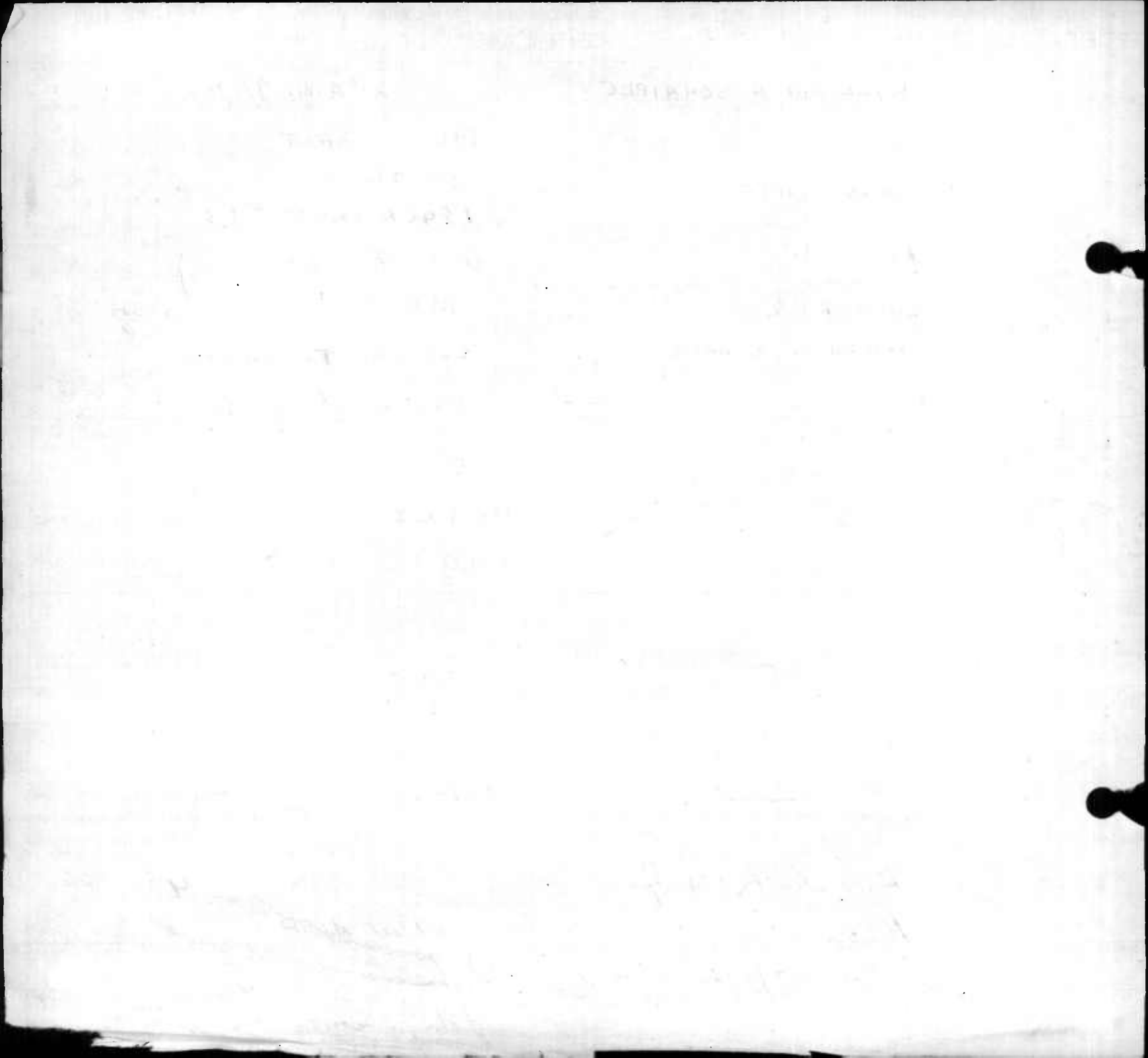
| BIRTH NO. 66 09024 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09024 | |
|--|--|-------------------------|--|--|--|--|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Baber, Ellen Marie | | | | Sept. 1, 1966 7:30 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY | | | |
| 5. SEX Female | | | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 8/18/1897 | | | | 9. AGE (In years last birthday) 69 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME Clayborne Gordon | | | |
| 14. MOTHER'S MAIDEN NAME Emma Roy | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 223-28-4601 | | | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X14023X | | | | CAUSE OF DEATH (A) CVA DUE TO (B) Hypertension (systolic) DUE TO (C) Generalized ASCVD | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Luetie aortitis | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Nov. 23, 1965 to Sept. 1, 1966 , that (1) (we) last saw the deceased alive on Sept. 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Carl Winterstein | | | | | | 23B. DATE SIGNED 9/1/66 | |
| 23C. PHYSICIAN'S NAME (Type) Carl Winterstein | | | | | | 23D. ADDRESS Baltimore City Hosp. 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/5/66 | | 24C. NAME OF CEMETERY or CREMATORY Comilla Baber Cemetery | | 24D. LOCATION (City, town, or county) (State) Chilesburg Caroline Co. Va | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1966 | | | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS Herbert Nutter 3035 W. North Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--|---|--|
| BIRTH NO. 66 09025 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09025 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM A. SCHAIBLE | | 2. DATE AND HOUR OF DEATH 2:10 A.M. 9/6/66 ¹⁰ / ₁₁ AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSP | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1846 N. GAY ST #13 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 6-6-18 | 9. AGE (In years last birthday) 48 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY <i>General Labor</i> | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ARTHUR SCHAIBLE | | 14. MOTHER'S MAIDEN NAME LILLIAN FROM BRO | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT <i>John Schaible</i> | |
| 18. 410X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHF | | CAUSE OF DEATH (A) DUE TO CHF | | ADDRESS <i>10 E. Gittings</i> <i>Balt 30 W 51st</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO MS & MI | | INTERVAL BETWEEN ONSET AND DEATH SEVERAL YRS | |
| (C) DUE TO RHD | | | | SEVERAL YRS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9-1-66</u> 19 to <u>9-6-66</u> 19, that (I) (we) last saw the deceased alive on <u>9-6-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>H. Louden Kieracofe</i> | | | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) H. Louden Kieracofe | | | | 23D. ADDRESS UNIV. HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME OF CEMETERY or CREMATORY Landon Park | |
| 24D. LOCATION (City, town, or county) (State) Balt Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | | |
| 25B. NAME OF REGISTRAR <i>John J. Chomayson Jr.</i> | | 25C. FUNERAL DIRECTOR <i>John J. Chomayson Jr.</i> | | 25D. ADDRESS <i>280 E. St.</i> | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

William C. Arrington

2. DATE AND HOUR PRONOUNCED DEAD

9/3/66

7:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2917 N. Calvert Street

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

August 10, 1917

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stationary Engineer Mfrgr. Plant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin F. Arrington

14. MOTHER'S MAIDEN NAME

Lula Vandyke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

212 10 7373

17. INFORMANT

ADDRESS

James. W. Arrington 3700 Hickory Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Massive internal bleeding
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Stab wound of abdomen
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2917 N. Calvert St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 3 66 12:30a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE AT
WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7 Sep 66

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 8, 1966

Burgee Funeral Home, 3631 Falls Rd.

WVA

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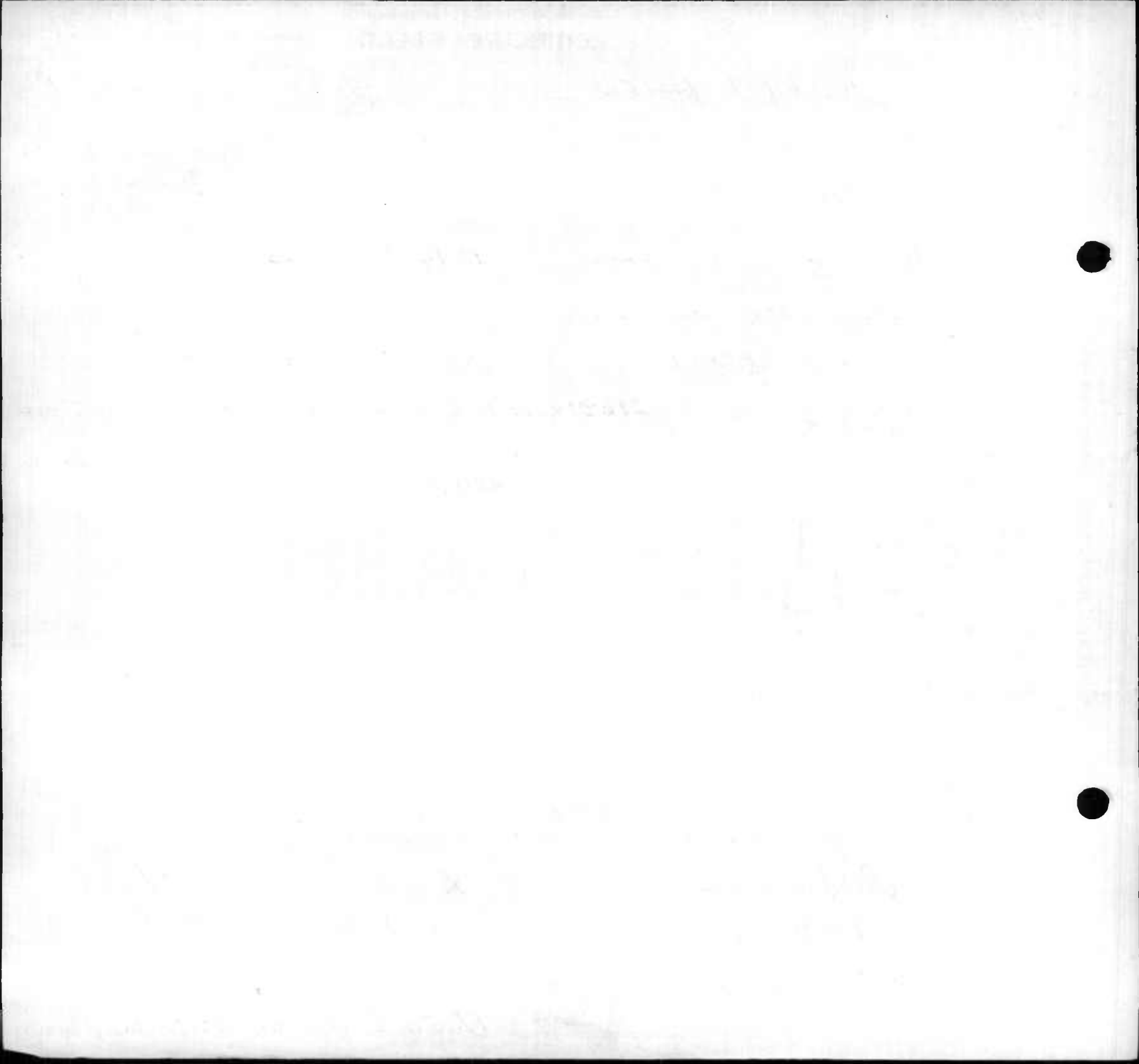
1941

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

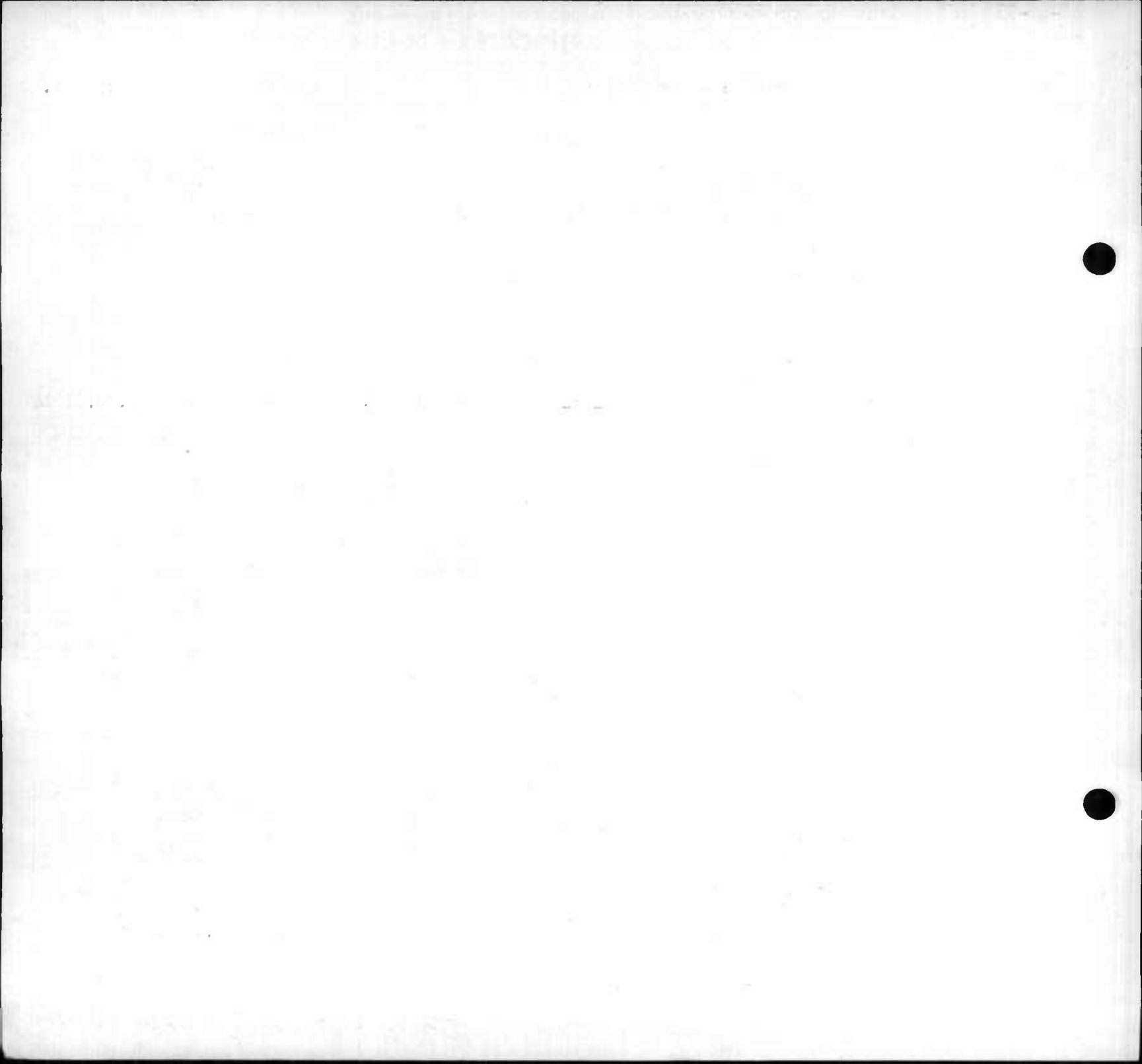
| BIRTH NO. 66 09027 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09027 | |
|--|-------------------------|--|-------------------------------------|--|------------------------------|--|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) RALPH E KEELIN | | | | 9/4/66 4:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3130 Chestnut Ave 21211 | | | |
| 5. SEX M | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-14-02 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY GEN MOTORS | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME EDWARD B. KEELEY | | | | 14. MOTHER'S MAIDEN NAME MARY J. FUNK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 21601-2214 | | 17. INFORMANT ELEANORA S. KEELEY | | ADDRESS 3130 CHESTNUT AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 420.01 VENTRICULAR FIBRILLATION 2 hours ASD | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar 1st 19 66 to Sept 4 19 66 , that (I) (we) last saw the deceased alive on 9/4/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE F M DUGAN | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/4/66 | |
| 23C. PHYSICIAN'S NAME (Type) F M DUGAN | | | | 23D. ADDRESS 15 E BIDDLE ST. BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY Pine Grove | | 24D. LOCATION (City, town, or county) (State) Balto Co, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Paul E. Taylor | | 25C. FUNERAL DIRECTOR Justin E. Donovan | | ADDRESS 3818 Polans Ave | |



FUNERAL DIRECTOR: IMPORTANT

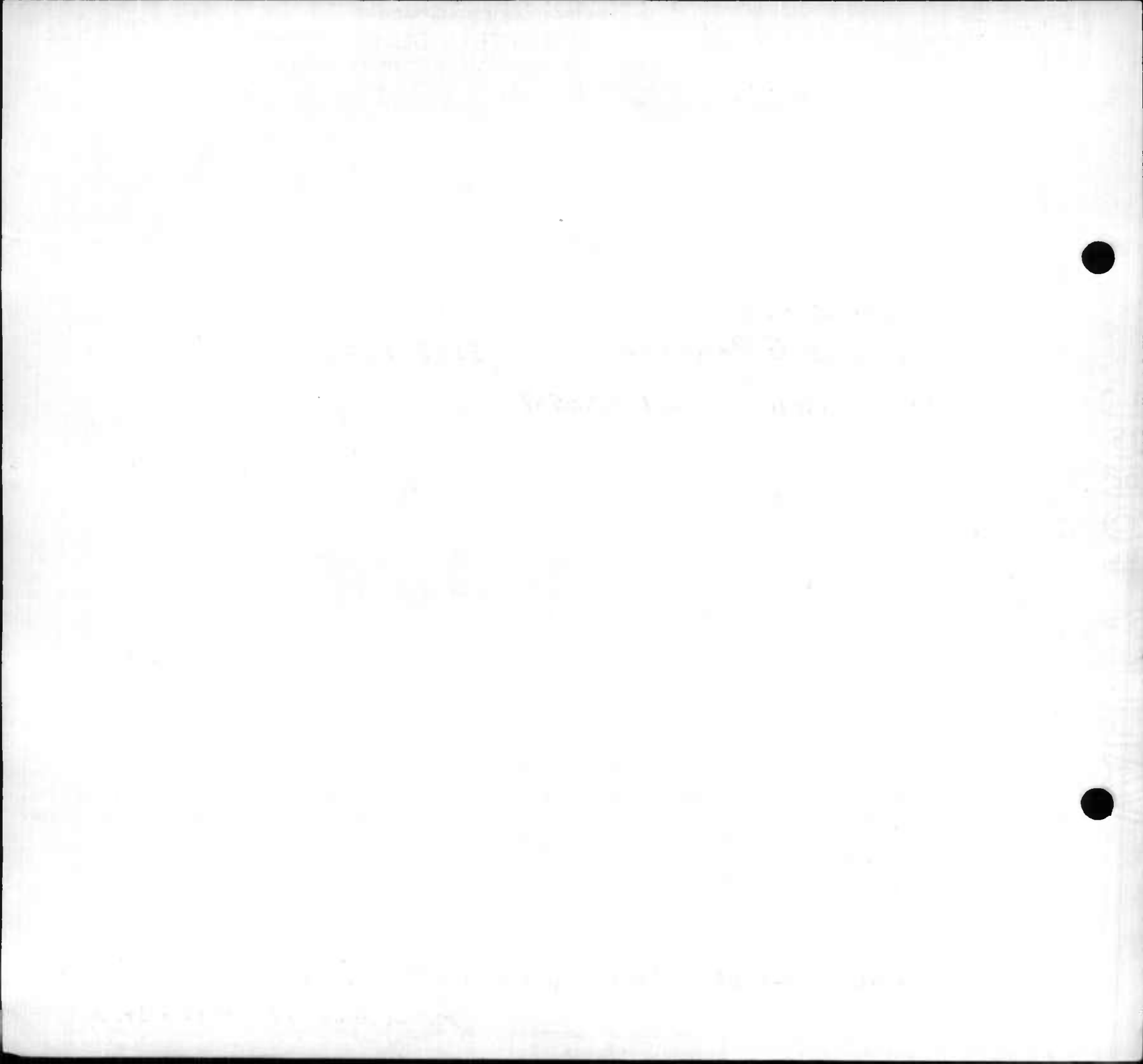
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|---|-----------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09028 | |
| BIRTH NO. 5-320 66 09028 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SEITZ, Agnes Bertha | | 2. DATE AND HOUR OF DEATH 9/4/66 11:35 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-03 D. STREET ADDRESS (If rural, give location) 300 LORRAINE AVENUE - 21221 | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4/5/92 |
| 9. AGE (In years last birthday) 74 | | 10. CITIZEN OF WHAT COUNTRY? 12-03 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Holland | | 14. MOTHER'S MAIDEN NAME Duvall | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-54-0167 | |
| 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave, Balto. Md. 21224 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 20. CAUSE OF DEATH (A) arteriosclerotic cardiovascular disease (B) arteriosclerotic cardiovascular disease (C) diabetes mellitus | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 22. DATE OF OPERATION 2 | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 26. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 27. INJURY OCCURRED | |
| 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that (I) (this hospital) attended the deceased from 8/25 19 66 to 9/4 19 66 , that (I) (we) last saw the deceased alive on 9/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 31. DATE SIGNED 9/5/66 | |
| 32. SIGNATURE David Swimmer | | 33. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO., MD. 21224 | |
| 34. BURIAL CREMATION, REMOVAL (Specify) Burial | | 35. DATE 9/7-1966 | |
| 36. NAME OF CEMETERY or CREMATORY Mountain View | | 37. LOCATION (City, town, or county) (State) Howard & Md | |
| 38. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 39. NAME OF REGISTRAR Frank H. Seitz | |
| 40. FUNERAL DIRECTOR 814 W 36 St | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|--|---|
| BIRTH NO. 66 09029 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09029 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PARRISH, MICHAEL G | | | 2. DATE AND HOUR OF DEATH 9/4 1966 9:08 PM. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3728 ELM AVE 21211 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6/12 1916 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSE MAN | | 10B. KIND OF BUSINESS OR INDUSTRY FOOD FAIR WAREHOUSE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME HERMAN G PARRISH | | | 14. MOTHER'S MAIDEN NAME ELIZABETH DARBY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII | | 16. SOCIAL SECURITY NO. 213-05-0567 | | 17. INFORMANT Hosp. Chart. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-20-11 ACUTE MYOCARDIAL INFARCTION | | | INTERVAL BETWEEN ONSET AND DEATH about 2 hours | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) ASCVD | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/4 1966 to 9/4 1966, that (I) (we) last saw the deceased alive on 9/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Magnus Petursson | | | | 23B. DATE SIGNED 9/4 '66 | |
| 23C. PHYSICIAN'S NAME (Type) MAGNUS PETURSSON | | | | 23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-8-66 | | 24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY | |
| | | | | 24D. LOCATION (City, town, or county) (State) TICKESVILLE BALTO. Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Frank H. Seitz 814 W 36th St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09030 | |
|--|-------------------------|--|---------------------------------------|--|---|
| BIRTH NO. 66 09030 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WALTER J. WEBER | | 2. DATE AND HOUR OF DEATH Sept 9 1966 11:12 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GEN. HOSP | | A. STATE Maryland B. COUNTY Anne Arundel | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 32-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) Rt 1 Box 169 | | | |
| 5. SEX MALE | 6. RACE CAUC. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-14-1910 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 10B. KIND OF BUSINESS OR INDUSTRY Beth Steel | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WALTER WEBER | | 14. MOTHER'S MAIDEN NAME Emma Lagle | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II | | 16. SOCIAL SECURITY NO. 215-09-9746 | | 17. INFORMANT Patient | |
| 18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA OF Lung DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 months | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-15 19 66 to 9 -4 19 66 , that (I) (we) last saw the deceased alive on 9-4-66 19 66 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William F. Smith | | | | 23B. DATE SIGNED 9-4-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 7, 1966 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park | |
| 24D. LOCATION Ritchie Hwy., A.A.Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR George J. Gonce | |
| 25C. FUNERAL DIRECTOR George J. Gonce | | ADDRESS 4001 Ritchie Hwy., Baltimore | | | |

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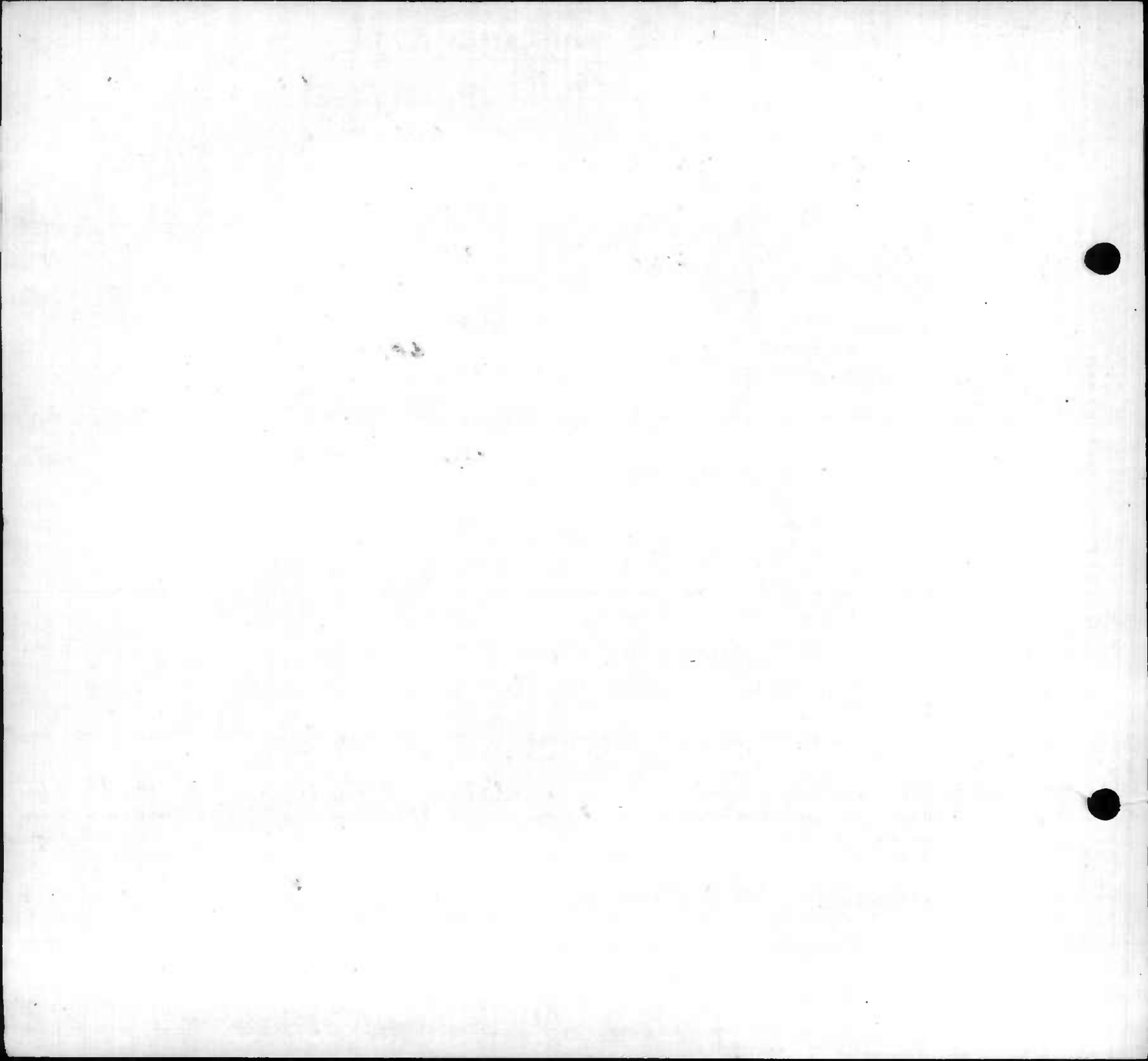
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. <u>66-1981266 09031</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 09031</u> | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY BOY MCDADE</u> | | | 2. DATE AND HOUR OF DEATH <u>9/2/66</u> <u>3:15</u> P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSPITAL</u> <u>100 N. Calhoun St.</u> <u>Baltimore, Maryland</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>21-02</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>150 Washington Blvd.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEWBORN</u> | 8. DATE OF BIRTH <u>9/2/66</u> | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <u>SHERMAN MCDADE</u> | | | 14. MOTHER'S MAIDEN NAME <u>GENORA SMITH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>IMMATUREITY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2:50 PM 9/2/66</u> to <u>3:15 PM 9/2/66</u> , that (I) (we) last saw the deceased alive on <u>9/2</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. Engstrom</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/2/66</u> |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| | | | | <u>FR. SP. Hosp. Disposal BALTO. MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 8 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460

66 09032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09032

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EDNA G. Muller

2. DATE AND HOUR OF DEATH

10:45 AM 9/6/66

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

SOUTH BALTIMORE GENERAL
HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 25

D. STREET ADDRESS (If rural, give location)

3715 Brooklyn Ave

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

6/4/98

9. AGE (In years
last birthday)

68

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Smith

14. MOTHER'S MAIDEN NAME

Fannie Torgan

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family Same

ADDRESS

18. 15331

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Carcinoma of sigmoid

6 months

(B) DUE TO

Colon with metastasis
Renal Failure

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work

Not While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 15 1966 to Sept 6 1966.
that (I) (we) last saw the deceased alive on Sept 6 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen Hameroff

M.D.

Attending
Phys.

Mod.
Director

Staff
Phys.

23B. DATE SIGNED

9/6/66

23C. PHYSICIAN'S
NAME (Type)

Stephen Hameroff

M.D.

23D. ADDRESS

South Baltimore General Hosp.

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

9-9-66

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill

24D. LOCATION

Baltimore

25A. DATE REC'D BY HEALTH DEPT.

SEP 8 1966

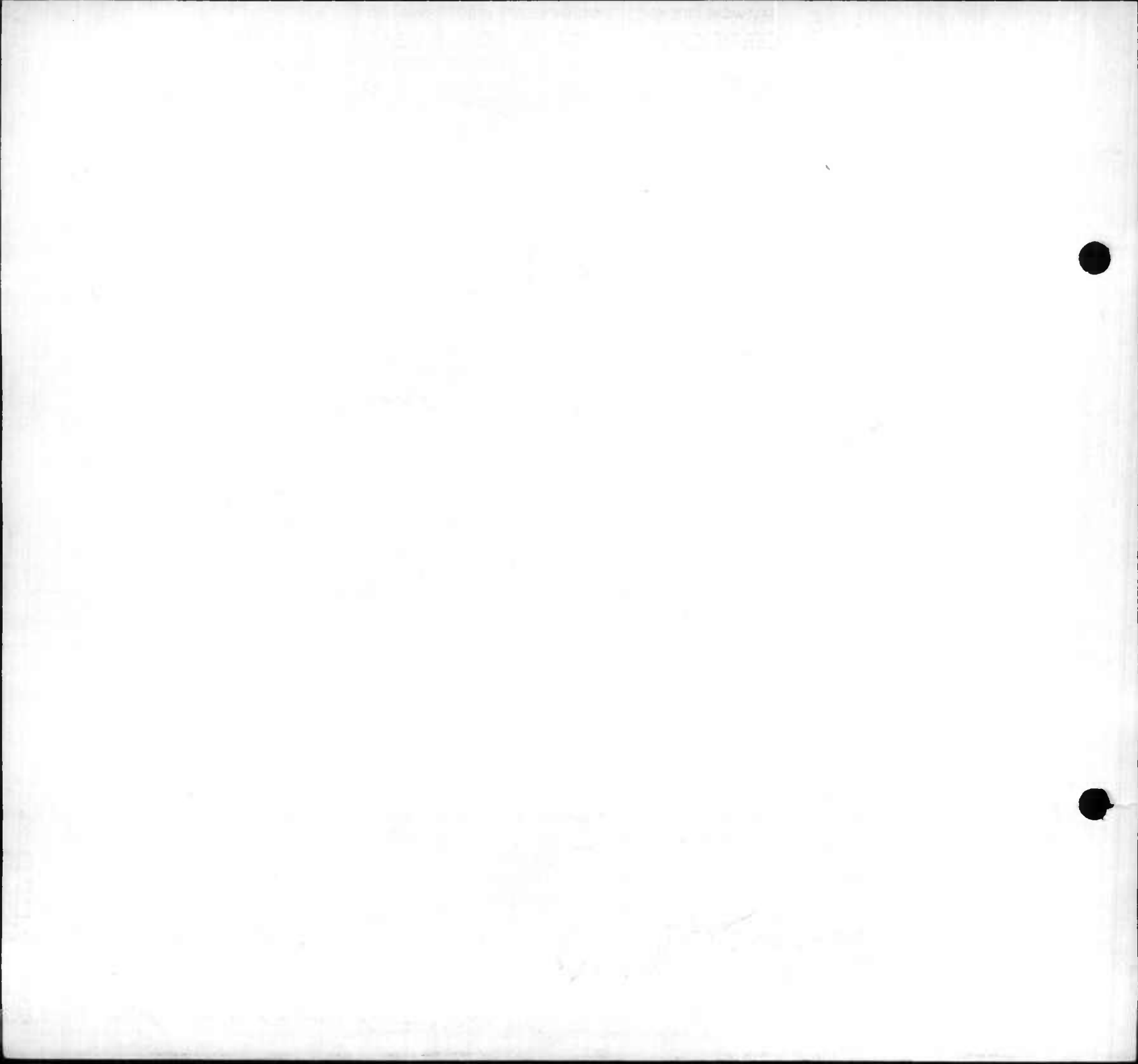
25B. NAME OF REGISTRAR

Robert E. Tolson

25C. FUNERAL DIRECTOR

737 Calapso Cer.

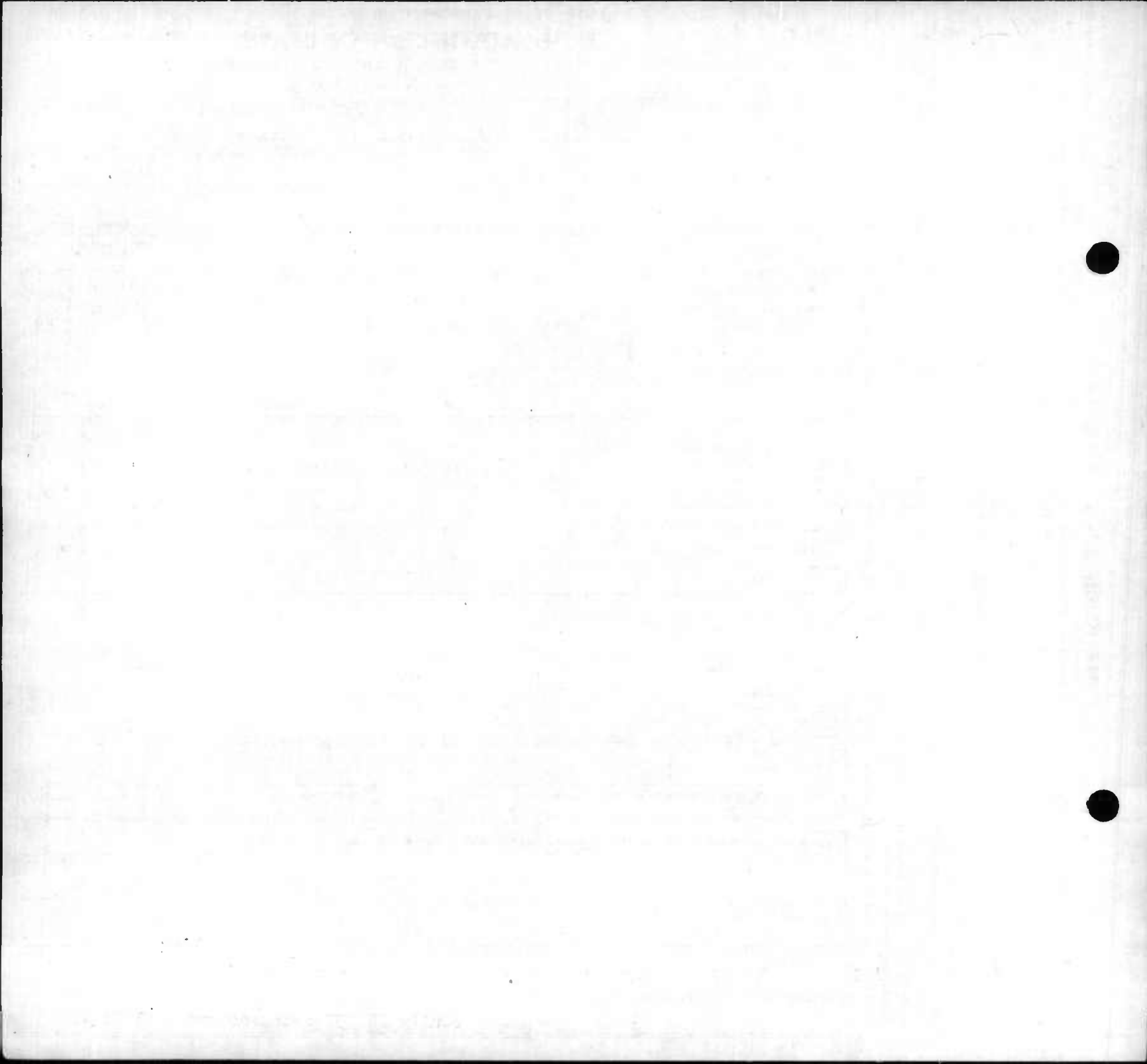
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

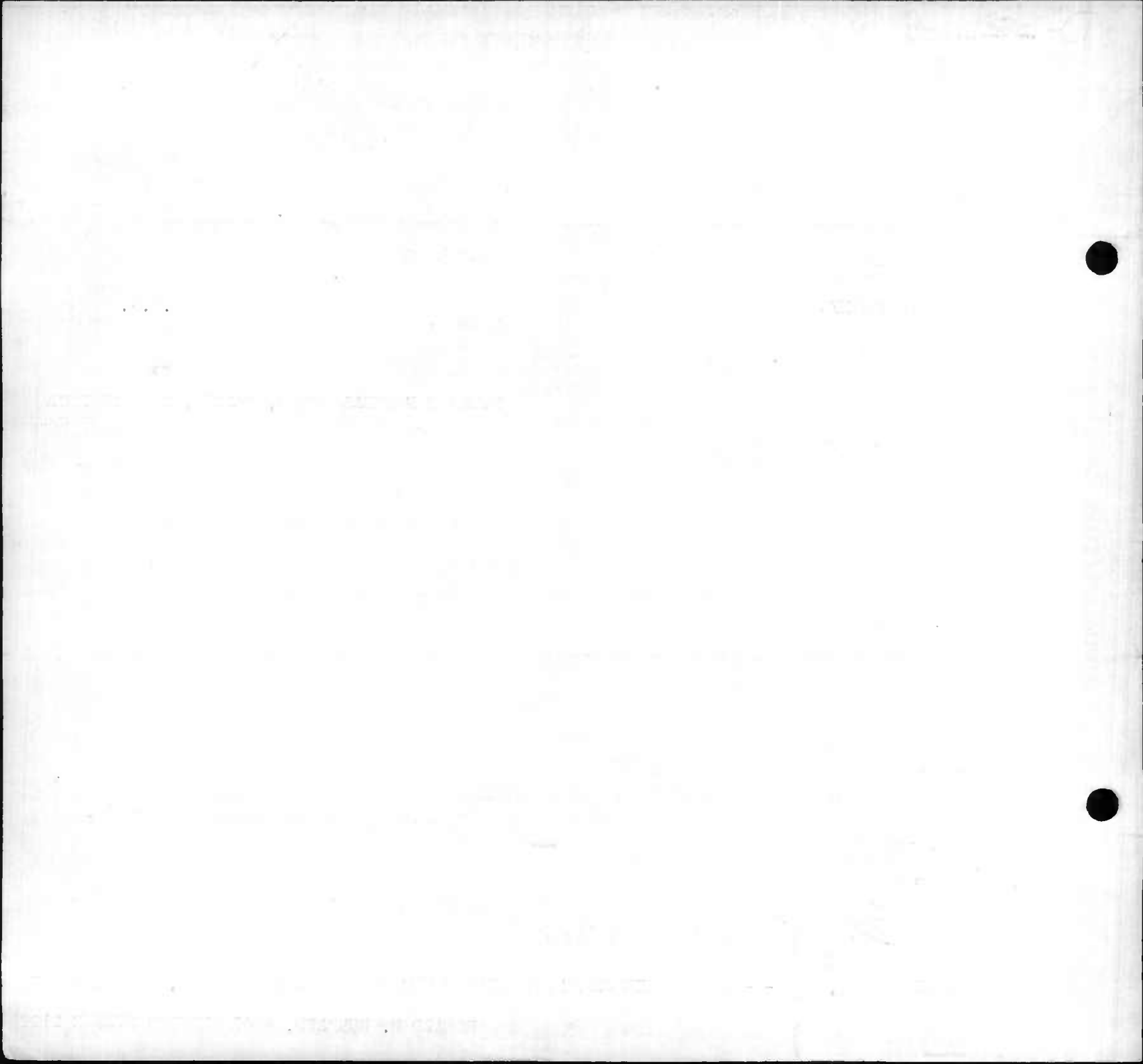
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|--|--|--|--|--|--|
| 66 09033 | | | | | Registered No. | | 66 09033 | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) HARBAUGH, IRVING B | | | | | 9/7/66 2:45 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL | | | | | A. STATE MARYLAND B. COUNTY ANNE ARUNDEL | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER 52-00 | | | | |
| D. STREET ADDRESS (If rural, give location) STONY RUN ROAD | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/27/05 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRIAL ENGINEER | | | 10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SAMUAL V HARBAUGH | | | | | 14. MOTHER'S MAIDEN NAME LAURA CARROLL | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 217-03-5652 | | 17. INFORMANT ALLINE F HARBAUGH | | | ADDRESS STONEY RUN ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARCINOMA OF ESOPHAGUS DUE TO GASTRIC JUNCTION WITH METASTASES | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/27/1966 to 9/7/1966 , that (I) (we) lost saw the deceased alive on 9/7/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE John P Doerfer | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN P DOERFER FOR E SHIPLEY | | | | | 23D. ADDRESS MARYLAND GENERAL HOSPITAL BALTIMORE MARYLAND | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem | | 24D. LOCATION (City, town, or county) (State) Howard Co Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR Sept 8 1966 | | 25C. FUNERAL DIRECTOR McCully FH 237 Patapsco Ave | | | ADDRESS 21225 | |



FUNERAL DIRECTOR: IMPORTANT

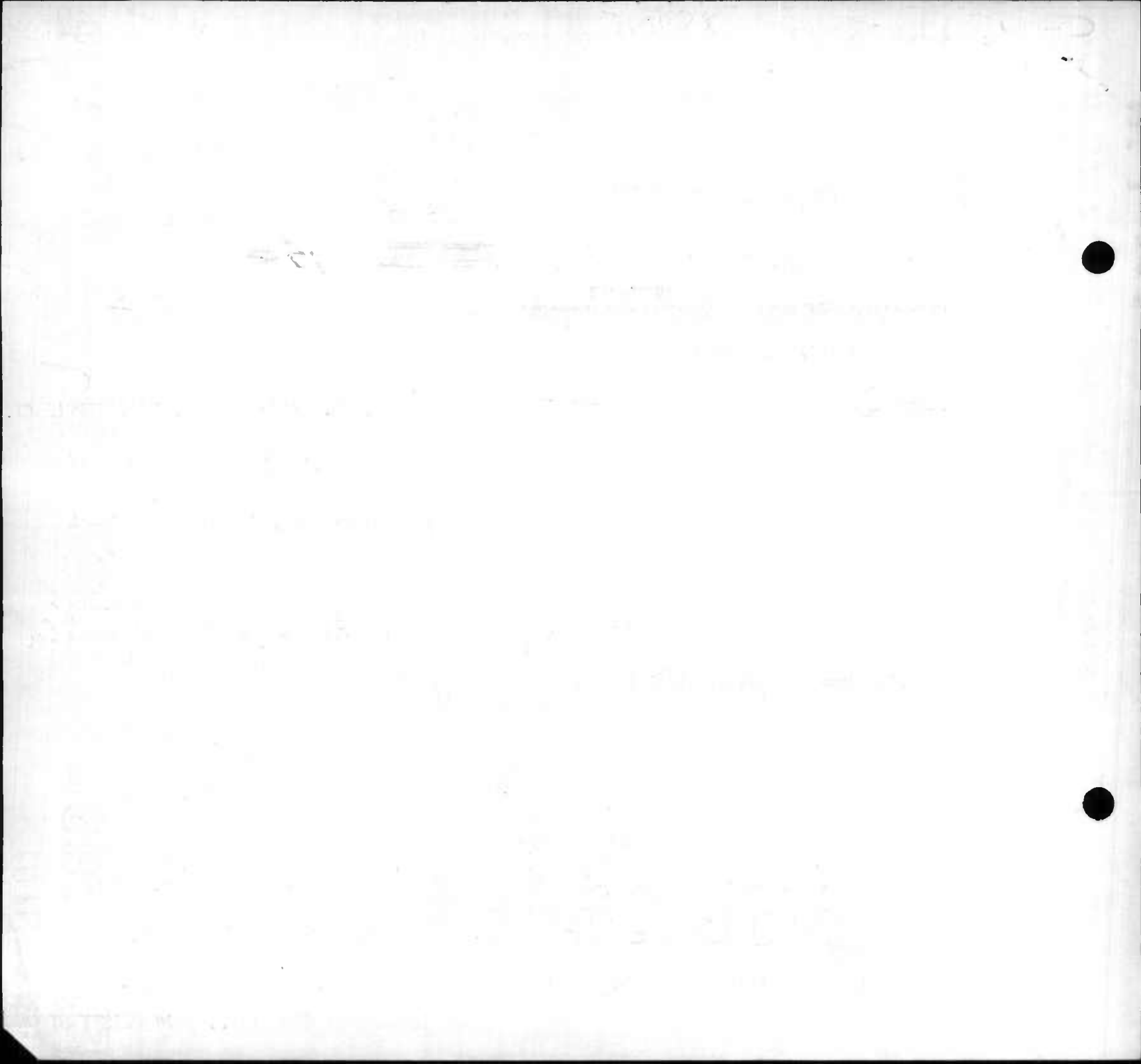
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09034 | |
|--|---------|--|---|--|--------------------------------|
| 66 09034 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | ELIZABETH S. DODDS | | 9-6-66 5.40 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE PENNSYLVANIA | | |
| THE JOHNS HOPKINS HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SHARON | | |
| | | | D. STREET ADDRESS (If rural, give location) 502 FORKER BLVD. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| FEMALE | WHITE | MARRIED | 7-26-02 | 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JAMES H. SCOTT | | | ESTELLA POWELL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | McMANUS FUNERAL HOME, SHARON, PENNSYLVANIA | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | 2 Days | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 18 1966 to Sept 6 1966, that (I) (we) last saw the deceased alive on Aug 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Robert S. Bentner M.D. | | | | 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Robert Bentner | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 9-9-66 | | HILLCREST MEMORIAL CEMETERY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | | | HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

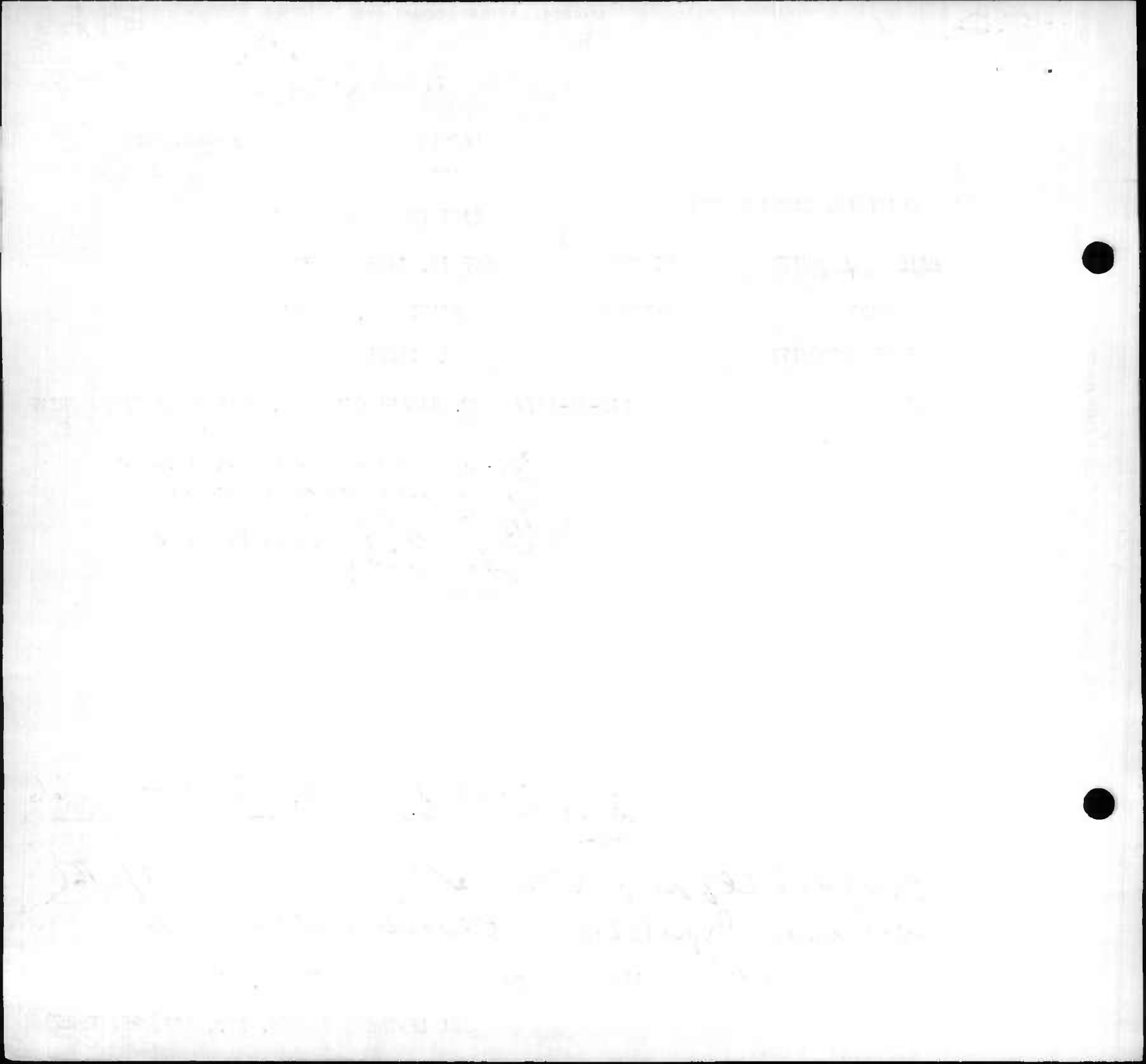
| | | | | | |
|--|---------------------|--|---------------------------------------|---|---|
| BIRTH NO. 66 09035 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09035 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Julius Caplan | | 2. DATE AND HOUR OF DEATH 2:40 PM 9-2-66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | 27-18 | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 3506 Spaulding Ave | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH [REDACTED] | 9. AGE (In years, last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL | | 10B. KIND OF BUSINESS OR INDUSTRY MERCHANT | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 13. FATHER'S NAME Morris CAPLAN | | 14. MOTHER'S MAIDEN NAME Esther ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. [REDACTED] | | 17. INFORMANT son, MR. DAVID CAPLAN, 7404 RIPPLE CT. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Chemical peritonitis | | CAUSE OF DEATH (A) DUE TO pyloric duodenal ulcer | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. remote pneumonectomy for Bronchogenic Ca | | 19A. DATE OF OPERATION 9-1-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated ulcer | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) WHERE DID INJURY OCCUR? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-1-66 19 to 9-2-66 19, that (I) (we) last saw the deceased alive on 9-2-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE P B Briscoe Jr | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-2-66 | |
| 23C. PHYSICIAN'S NAME (Type) P B Briscoe Jr | | M.D. 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/4/66 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN | |
| 24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR SQL LEVINSON & BROS INC., 6010 REISTERSTOWN | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

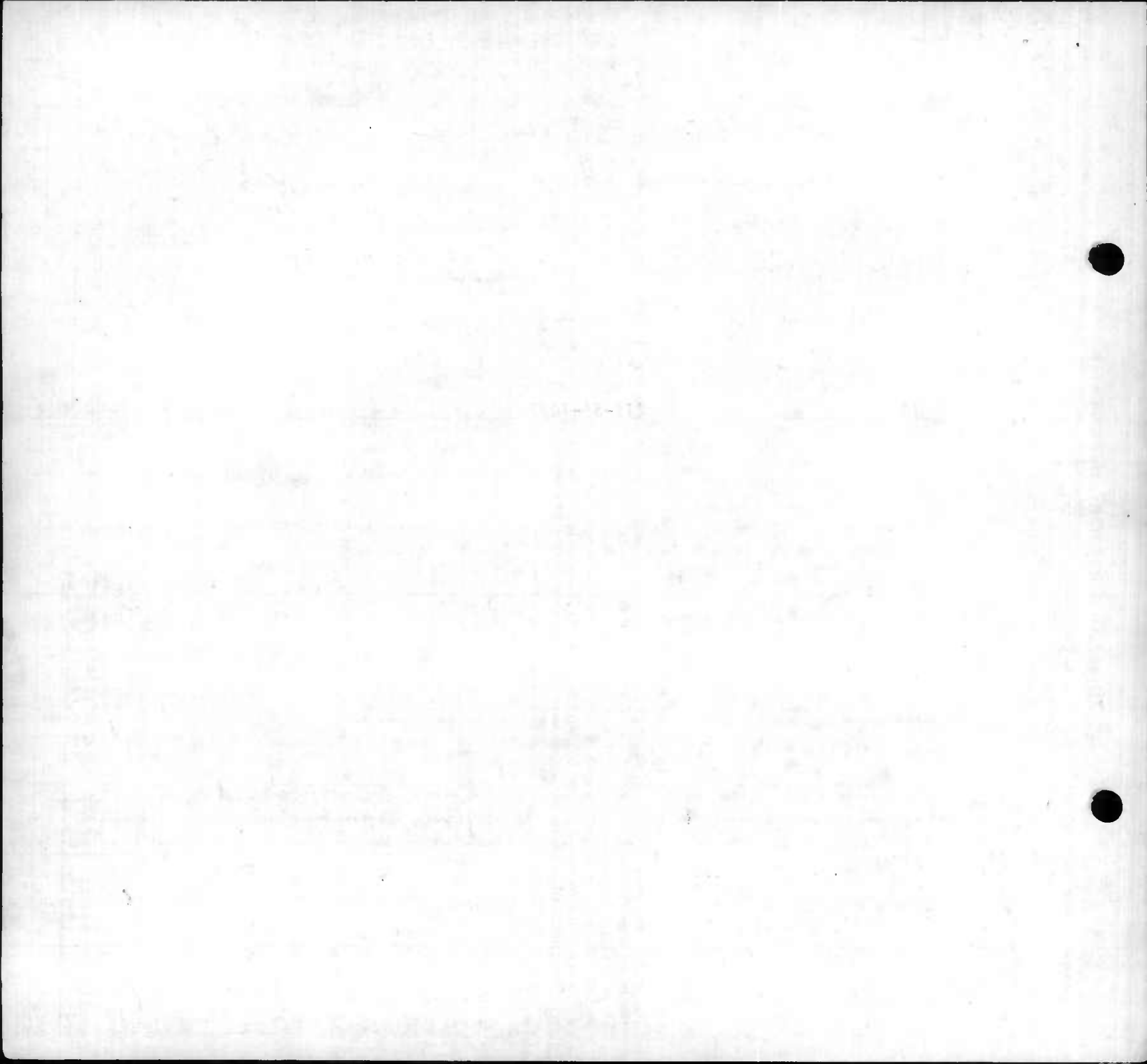
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09036 | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 66 09036 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Maurice B. Horowitz | | Sept 4 1966 11:59 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BELVEDERE NURSING HOME | | A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3323 LYNNE HAVEN DRIVE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH OCT 10, 1893 | 9. AGE (In years last birthday) 72 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JACOB HOROWITZ | | 14. MOTHER'S MAIDEN NAME MARY KLEINMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-32-2974 | 17. INFORMANT MR. SAMUEL GOLDBERG, 3323 LYNNE HAVEN DRIVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Cardio Respiratory Failure Congestive Heart Failure Hrt. C.V. H.D. (B) DUE TO Cerebral arteriosclerosis (C) DUE TO Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 13 1955 to Sept 4 1966 that (I) (we) last saw the deceased alive on Sept 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William Appleford | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) William Appleford | | 23D. ADDRESS 5501 Park Heights Dr. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9/6/66 | 24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Sol Levinson | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

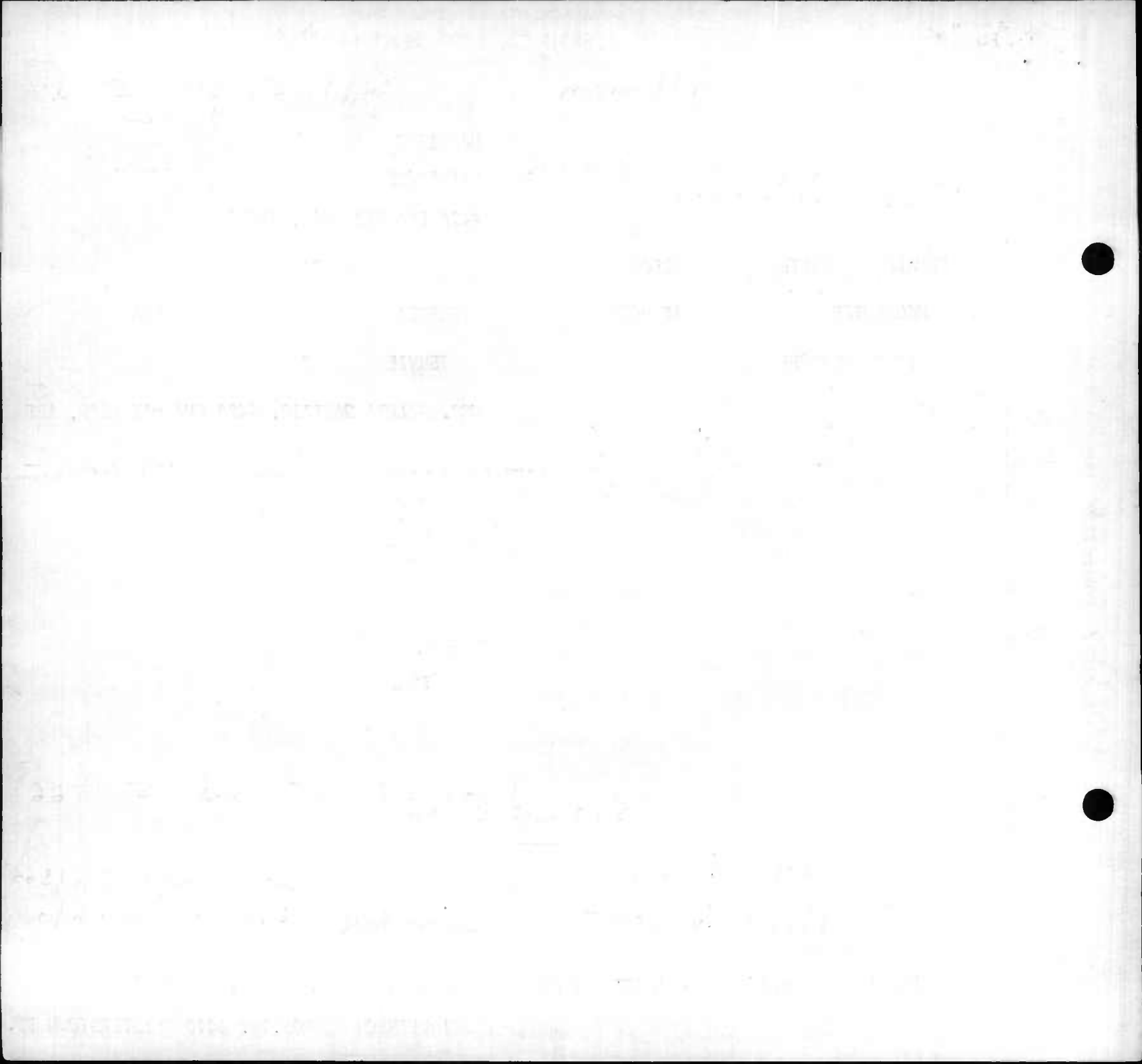
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 09037</u> | |
|---|----------------------|---|-----------------------------------|---|--|--|-----------------------|
| BIRTH NO. <u>66 09037</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Rebecca Stulman</u> | | 2. DATE AND HOUR OF DEATH <u>3:10 p.m. 9/5/66</u> <u>38</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Belvedere Nursing Home</u> <u>W. Belvedere Ave</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4116 W Rogers Ave</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>3/20/1886</u> | 9. AGE (In years last birthday) <u>80</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Labon Silverstein</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rebka</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>219-36-1037</u> | | 17. INFORMANT <u>Mrs Sarah S. Zierler - 3608 Croftland Rd</u> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>331X1</u> <u>Arterio-sclerotic C.V.A.</u> <u>with cerebral vascular accident</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u> <u>Oct 65</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>none</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 13</u> 19 <u>65</u> to <u>Sept 5</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Sept 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Sarah S. Zierler</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/5/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Sarah S. Zierler</u> | | | | 23D. ADDRESS M.D. <u>2502 Eutan Place</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/7/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Providence Rudman</u> | | 24D. LOCATION (City, town, or county) (State) <u>Rosedale, Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 8 1966</u> | | 25B. NAME OF REGISTRAR <u>John E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Sal Legunon & Bros</u> | | ADDRESS <u>6010 Rest. Rd</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

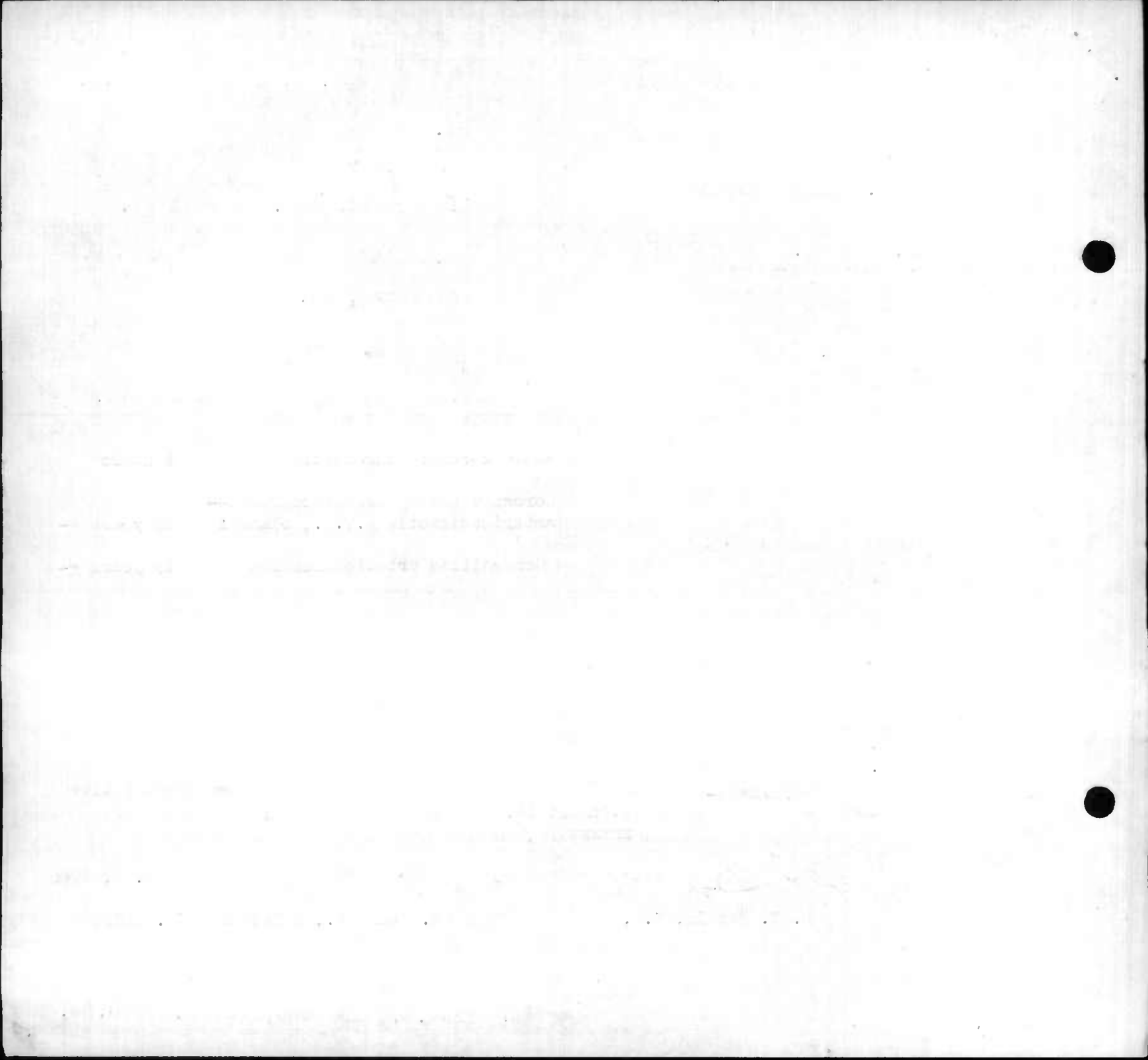
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09038 | |
|---|-------------------------|---|-------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | Registered No. X 66 09038 | |
| BIRTH NO. 66 09038 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Helen Feldman</u> | |
| 2. DATE AND HOUR OF DEATH <u>Sept. 5, 1966</u> <u>5</u> a.m. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>9 LEVINDALE, HEBREW HOME AND INFIRMARY.</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balt</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4420 EVA MAY ROAD, APT 2 E</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>76</u> | 9. AGE (In years last birthday) <u>76</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>HIRSCH BERKOFF</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>JENNIE ?</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS. SYLVIA DANTZIC, 4420 EVA MAY ROAD, APT 2E</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>151X I</u> <u>Upper gastro-intestinal hemorrhage - carcinoma of stomach probably -</u> | | CAUSE OF DEATH <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>10 hours -</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 27, 1965</u> to <u>Sept. 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>September 5, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Ruth Willmer</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Sept. 5, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Ruth Willmer</u> | | 23D. ADDRESS <u>Levin Dale, Hebrew Home and Infirmary</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/6/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>UNITED HEBREW</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 8 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Feldman</u> | | 25C. FUNERAL DIRECTOR <u>SOL EVINSON & BROS. INC 6010 REISTERSTOWN RD.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 66 09039 | | CERTIFICATE OF DEATH | | Registered No. 66 09039 | |
|--|----------------------|---|--|---|--|---|--|------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Lillie Olive Doyle | | | | 2. DATE AND HOUR OF DEATH Sept. 4, 1966 4:20 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2813 Maudlin Ave. Morrell Pk. | | | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH Apr. 16, 1903 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Frostburg, Md. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME George T. Inks | | | | 14. MOTHER'S MAIDEN NAME Alice E. Layman | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mrs. Mary McCue, 2813 Maudlin Ave. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.11 Acute coronary thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Coronary artery atherosclerosis-- | | (B) arteriosclerotic C.V.D., class I 15 years + | | | |
| | | | | (C) Generalized arteriosclerosis | | 15 years + | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (the deceased) attended the deceased from 19 60 to present time , that (I) (we) last saw the deceased alive on August 14, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE R. V. Rangle, M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 6, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) R. V. Rangle, M.D. | | | | 23D. ADDRESS 2938 St. Paul St., Baltimore, Md. 21218 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9/7/66 | | 24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Fred. A. Cole | | 25C. FUNERAL DIRECTOR ADDRESS Fred. A. Cole Home, 1915 W. Balto. St. 21225 | | | | | |



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R-152

66 09040

BALTIMORE CITY HEALTH DEPARTMENT

66 09040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

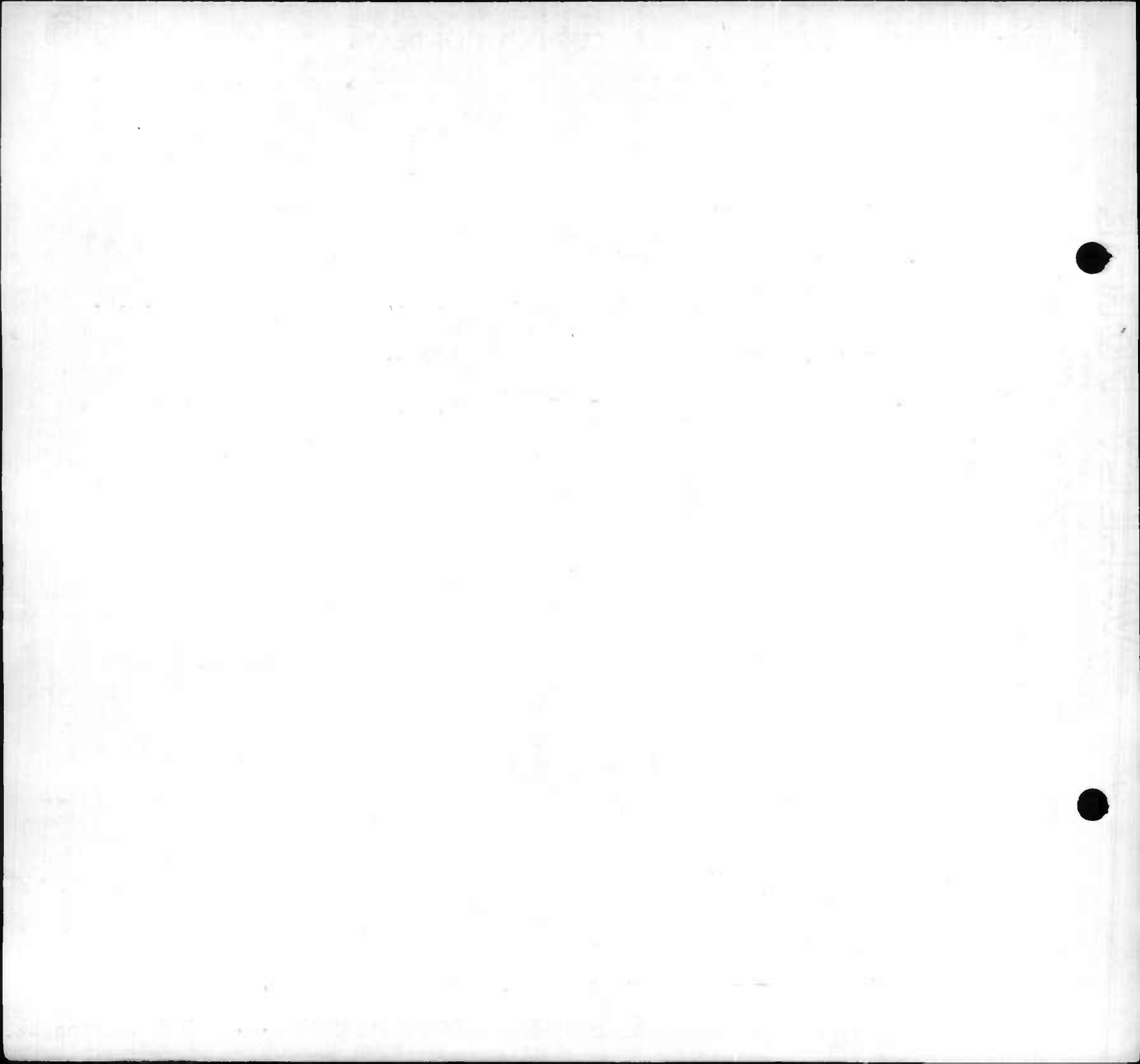
M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|--|--|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) Willie Robinson | | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/6/66 6:55 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 39 Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1701 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 631 W. Biddle St. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Dec 18 - 1911 | 9. AGE (In years lost birthday) 54 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Middlesex Co. Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Robinson | | | | 14. MOTHER'S MAIDEN NAME Kitty Lockley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-01-2021 | | 17. INFORMANT Mrs. Rosette Robinson | | ADDRESS 631 W. Biddle St. | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/6/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9-10-66 | | 23C. NAME OF CEMETERY or CREMATORY Mount Calvary | | 23D. LOCATION (City, town, or county) (State) A. A. Co., Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 24B. NAME OF REGISTRAR R. G. E. Johnson | | 24C. FUNERAL DIRECTOR Morton & Dye H. H. | | ADDRESS 1701 Laurens St. | |

WILLIE FONGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

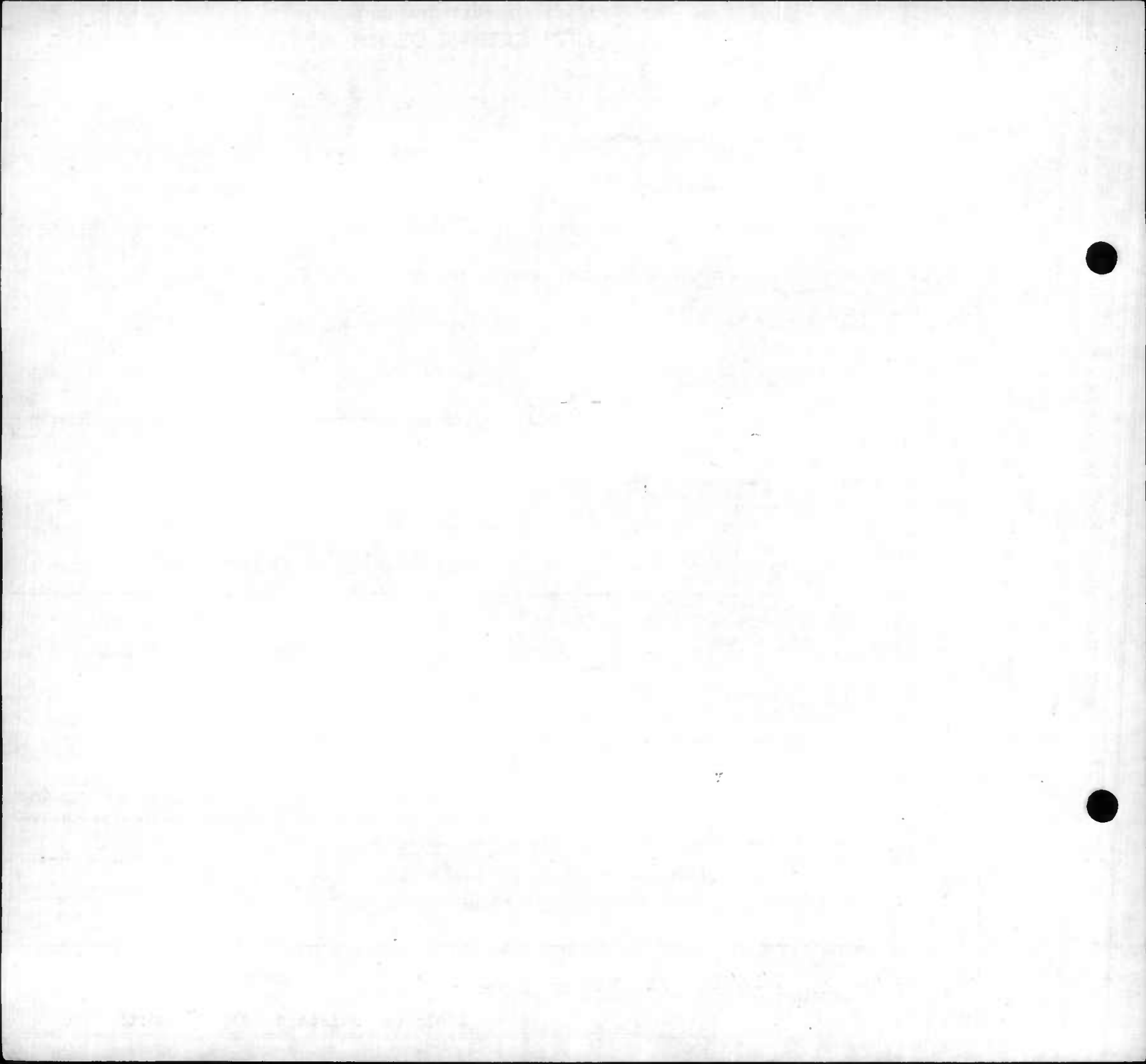
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------|--|---|--|--|
| 66 09041 | | CERTIFICATE OF DEATH | | 66 09041 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| JAMES ALLEN JONES | | September 5, 1966 4:30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| 00 2436 Eutaw Place | | D. STREET ADDRESS (If rural, give location) 2436 Eutaw Place | | | |
| | | 13-01 | | | |
| 5. SEX M. | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH August 26, 1902 | 9. AGE (In years last birthday) 64 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | | 11. BIRTHPLACE (State or foreign country) Balto., Maryland | |
| 13. FATHER'S NAME Andrew A. Jones | | | 14. MOTHER'S MAIDEN NAME Mary E. Allen | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 215-03-1753 | | 17. INFORMANT Mrs. I. Snowden | |
| | | | | ADDRESS 2436 Eutaw Place | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 163 X I CAUSE OF DEATH (A) Carcinoma of the Lung DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from January 19 66 to September 2 19 66, that (1) (we) last saw the deceased alive on September 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel R. Owings, Jr. | | | | 23B. DATE SIGNED September 7, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Samuel R. Owings, Jr. | | 23D. ADDRESS 909-11 N. Carey St. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-8-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Morton S. Dyett | | 25C. FUNERAL DIRECTOR F.H. 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

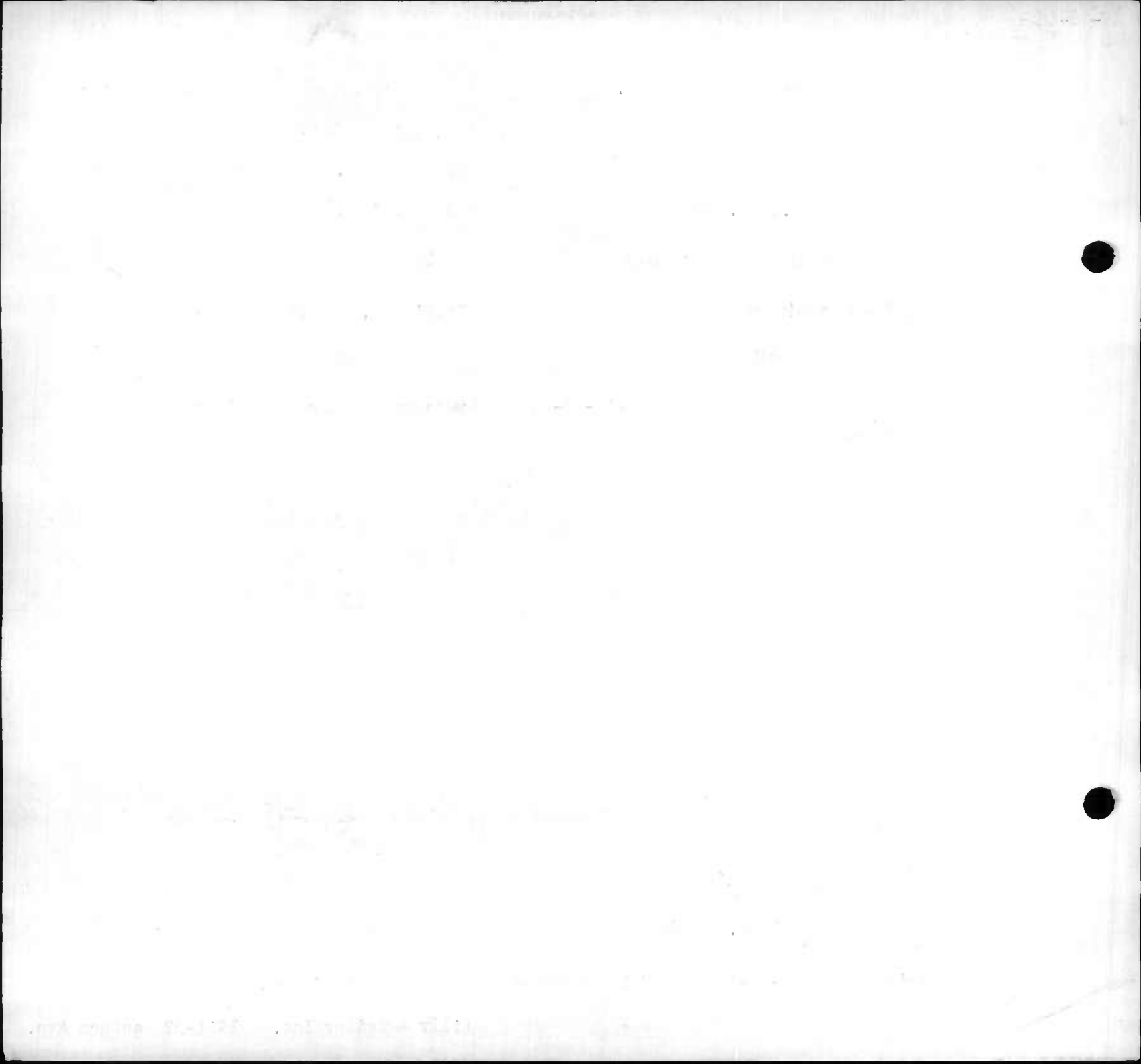
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09042 | |
|--|-----------|--|---|--|--|
| BIRTH NO. 66 09042 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) JAMES MOORE | | | 2. DATE AND HOUR OF DEATH 9-6-66 8:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | A. STATE MD. B. COUNTY 1702 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto | | |
| | | | D. STREET ADDRESS (If rural, give location) 1110 DRUID HILL AVE | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIV | 8. DATE OF BIRTH 12-23-10 | 9. AGE (In years last birthday) 55 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME LEVI MOORE | | | 14. MOTHER'S MAIDEN NAME ADA CHAMBERS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1943-1945 discharged | | | 16. SOCIAL SECURITY NO. 224-07-3700 | | 17. INFORMANT ADDRESS PT. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | | (A) SHOCK DUE TO | | 2 1/2 hrs. |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) UREMIA DUE TO | | 4 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CIRRHOSIS | | | (C) MALIGNANT NEPHROSCLEROSIS | | KNOW FOR 2 MRS |
| 19A. DATE OF OPERATION 2 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-1-1966 to 9-6-1966, that (1) (we) last saw the deceased alive on 9-6-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jay Martin Baranish | | | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) A A County Md | | 24E. NAME OF REGISTRAR Adolphus Halstead | | 24F. FUNERAL DIRECTOR ADDRESS 1206 W North Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09043 | |
|--|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 09043 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GOELLER, CONSTANTINE A. | | 2. DATE AND HOUR OF DEATH 7 September 1966 12 20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MD. 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTO. (If outside city limits, write RURAL and give township) 153-00 D. STREET ADDRESS (If rural, give location) 924 ESSEX SQ. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 12/28/83 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinest | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-03-4356 | | 17. INFORMANT Lawrence Goeller ADDRESS 328 Imla Street | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 72 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Klebsiella pneumoniae 7 weeks | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 22 August 1966 to 7 September 1966 , that (I) (we) last saw the deceased alive on 7 September 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel D. Foote | | | | 23B. DATE SIGNED 7 September 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DANIEL D. FOOTE | | | | 23D. ADDRESS BCH 4940 EASTERN AVE. BALTO. MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-10-1966 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Williams | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 1901-07 Eastern Ave. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T 4601

66 09044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 09044

| | | | |
|--|---------------------------|--|--|
| BIRTH NO. 66 09044 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>William Taylor</i> | | 2. DATE AND HOUR OF DEATH <i>September 6 1966 7-8A M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> COUNTY <i>16-07</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2832 Elliott Drive</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | D. STREET ADDRESS (If rural, give location) <i>2832 Elliott Drive</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>April 21 1900</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <i>66</i> |
| 13. FATHER'S NAME <i>William B. Taylor</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret Phoenix</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War I</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Jessie Taylor 2832 Elliott Drive</i> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hemiparesis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>July 12, 66</i> | |
| 19A. DATE OF OPERATION <i>63 + 64</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Legs amputated</i> | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1949</i> 19 <i>8/23</i> to <i>9-6th</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/23</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>RAYNER DROWNE, M.D.</i> | | 23B. DATE SIGNED <i>9/8/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>1500 EAST MADISON ST. BALTIMORE, MD. 21205</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sep 9/66</i> | |
| 24C. LOCATION (City, town, or county) (State) <i>Baltimore, Md. 21205</i> | | 24D. LOCATION (City, town, or county) (State) <i>5501 Frederick Ave</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John G. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>John G. Taylor</i> | | ADDRESS <i>1629 N. Carroll St</i> | |

SEP 8 1966

1-2-7

1-1-7

Hemibryozoa

Hydractinia A.2.
Cnidaria - Verrucaria
class

Dipodops deserti

22 + 44 legs - total

2-6-7

1977

8/23

X

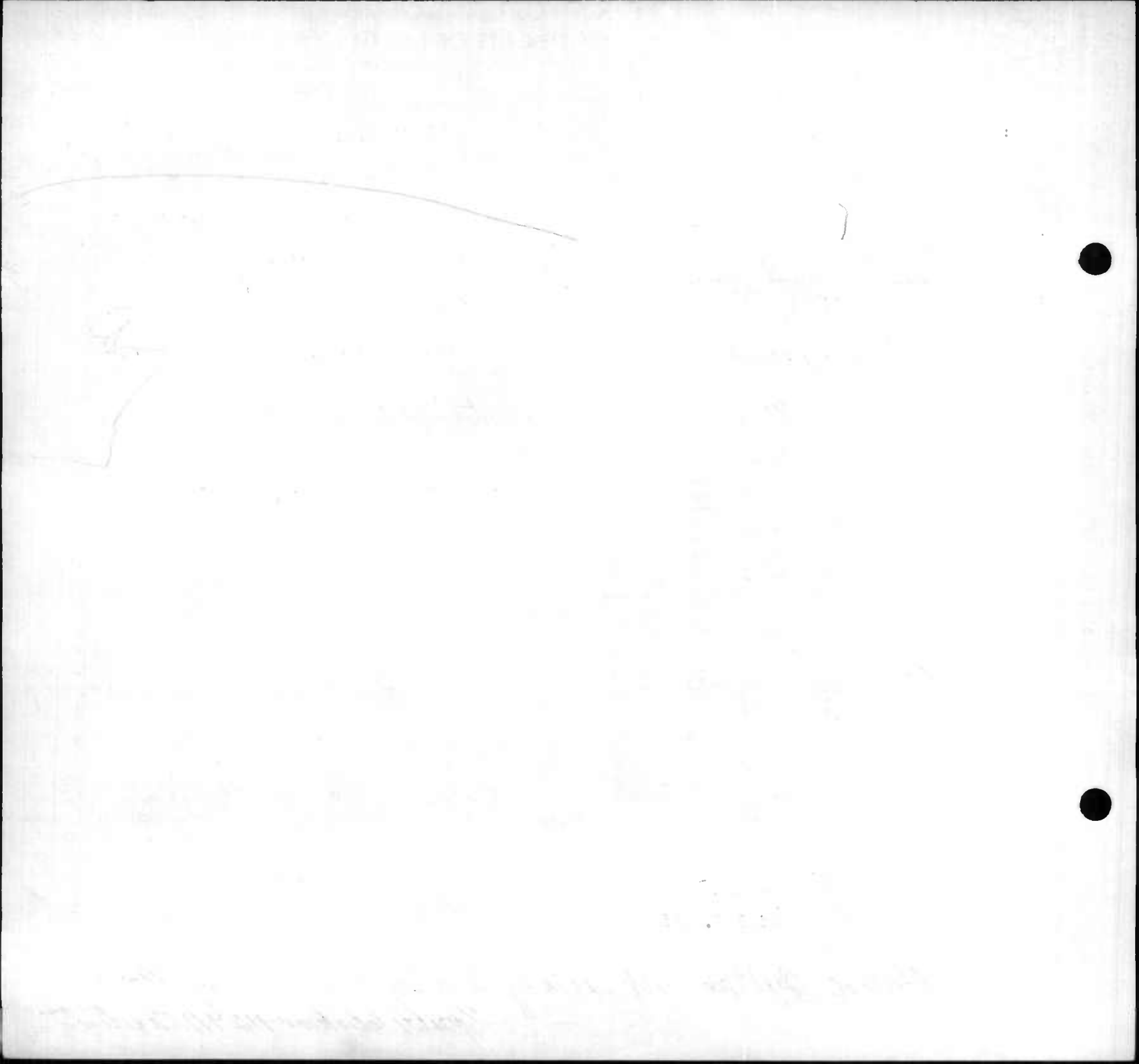
RECEIVED
FEB 23 1977
BIOLOGICAL

James

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09045 | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 66 09045 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Turner, Estelle R.</i> | | | 2. DATE AND HOUR OF DEATH <i>9/4/66</i> <i>8:30 P. M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-06</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3309 Bloomingdale Rd.</i> | | |
| 5. SEX <i>Female</i> | 6. RACE <i>negro</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>3/17/1917</i> | 9. AGE (In years last birthday) <i>49</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> |
| 13. FATHER'S NAME <i>unknown</i> | | | 14. MOTHER'S MAIDEN NAME <i>unknown</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <i>Hospital Records</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Ruptured aortic aneurysm, rt. ant. cerebral artery</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>03/13/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>craniotomy</i> | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/18/66</i> 19 to <i>9/4/66</i> 19, that (I) (we) last saw the deceased alive on <i>9/4/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel G. Lai</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/4/66</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i> | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sept 9/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Map Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i> | | 25A. DATE RECD BY HEALTH DEPT. <i>SEP 8 1966</i> | | 25B. NAME OF REGISTRAR <i>Alfred E. Hall</i> | |
| 25C. FUNERAL DIRECTOR <i>Joseph E. Eliezer</i> | | 25D. ADDRESS <i>11297 Carroll St</i> | | | |



66 09046

BALTIMORE CITY HEALTH DEPARTMENT

66 09046

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Evelyn Henderson

2. DATE AND HOUR PRONOUNCED DEAD

9/2/66 1:45 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1321 Eutaw Pl.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1321 Eutaw Pl.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

May 2, 1886

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Henderson

14. MOTHER'S MAIDEN NAME

Bessie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Anna Mae Hunter 1321 Eutaw Pl.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

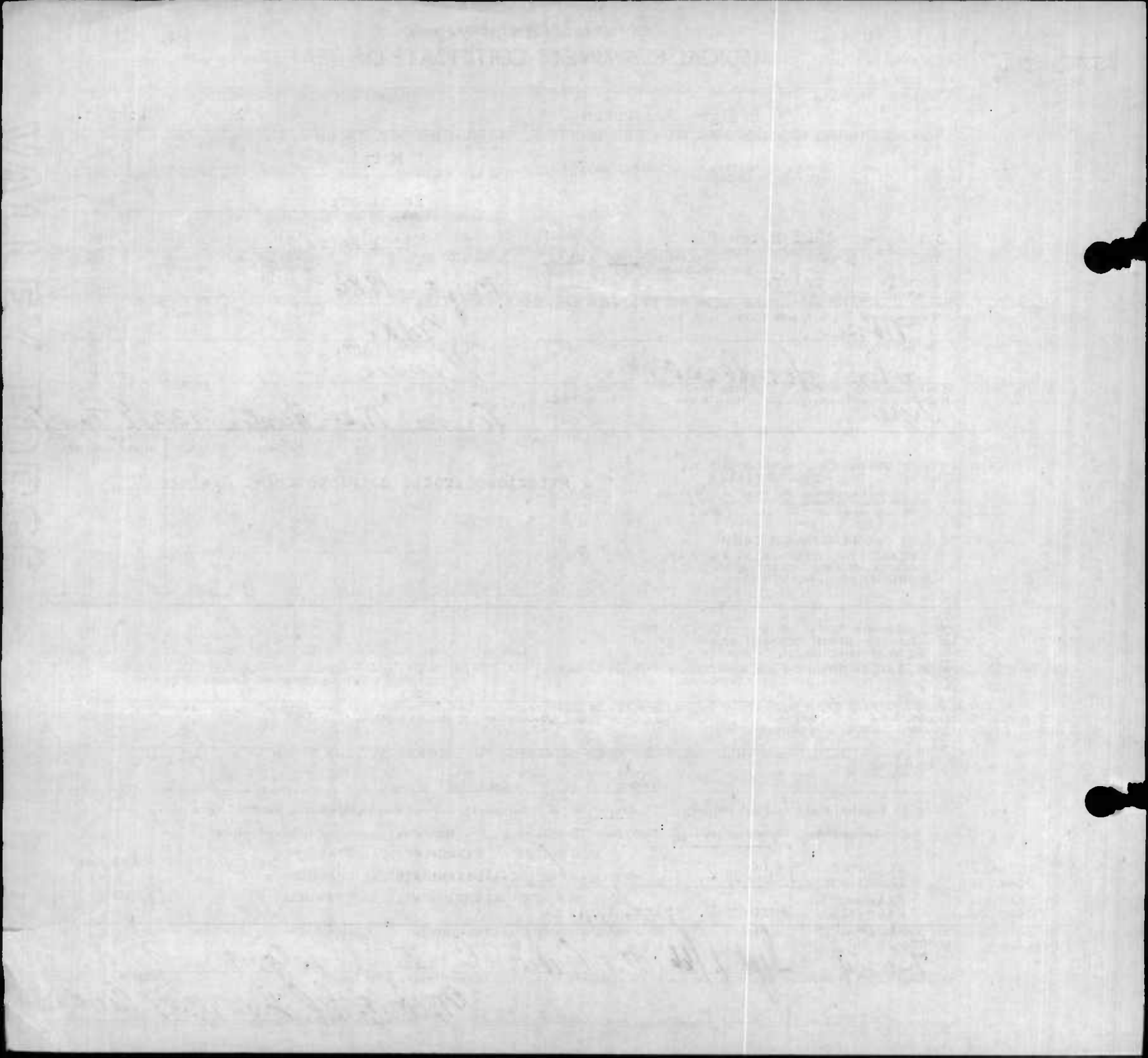
(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



66 09047

BALTIMORE CITY HEALTH DEPARTMENT

66 09047

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ella Marbel

2. DATE AND HOUR PRONOUNCED DEAD

9/2/66

6:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1229 E. Eager St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 16, 1899

9. AGE (In years last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Henderson N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Grandison

14. MOTHER'S MAIDEN NAME

Julia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

James Marbel 613 E. Chase St.

18. E 812.4 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Multiple injuries

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

W. Preston St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9 2 66 4:20 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Sept 7/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION (City, town, or county) (State)

Westport Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 8 1966

24B. NAME OF REGISTRAR

D. G. E. Fickens

24C. FUNERAL DIRECTOR

John E. Eickman 1129 N. Carroll St

ADDRESS

VALLEY FORD

66 09048

BALTIMORE CITY HEALTH DEPARTMENT

66 09048

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Travis Cottman Jr

2. DATE AND HOUR PRONOUNCED DEAD

9/3/66 5:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE 712 East 20 St Baltimore 18

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

712 E 20 St Baltimore, Md 19-09

D. STREET ADDRESS (If rural, give location)

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

June 25-1927 39

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Solomon

11. BIRTHPLACE (State or foreign country)

Durham N C

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Travis Cottman Sr

14. MOTHER'S MAIDEN NAME

Pearl Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

2

16. SOCIAL
SECURITY NO.

217-20-8890

17. INFORMANT

Family

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1417 Pennsylvania Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 3 66 3:45a

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot while attempting to burglarize home

22.

I certify that I held on inquiry ☐ inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 9-1966

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 8 1966

24B. NAME OF REGISTRAR

Robert E. Williams

24C. FUNERAL DIRECTOR

Robert E. Williams

ADDRESS

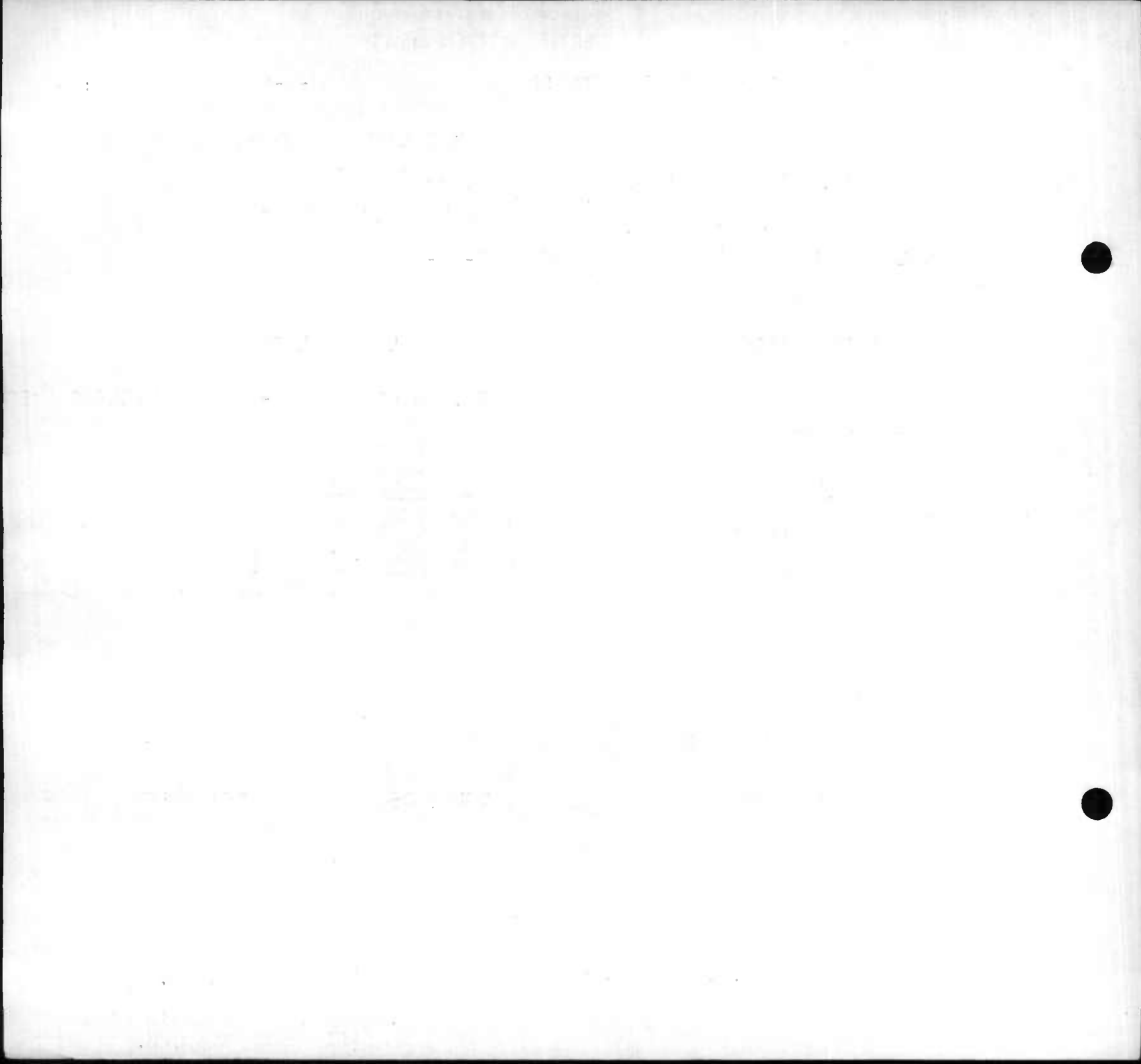
1701 N Bond St

WALLINGFORD

FUNERAL DIRECTOR: IMPORTANT

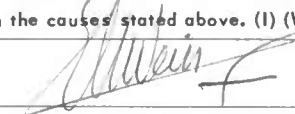
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

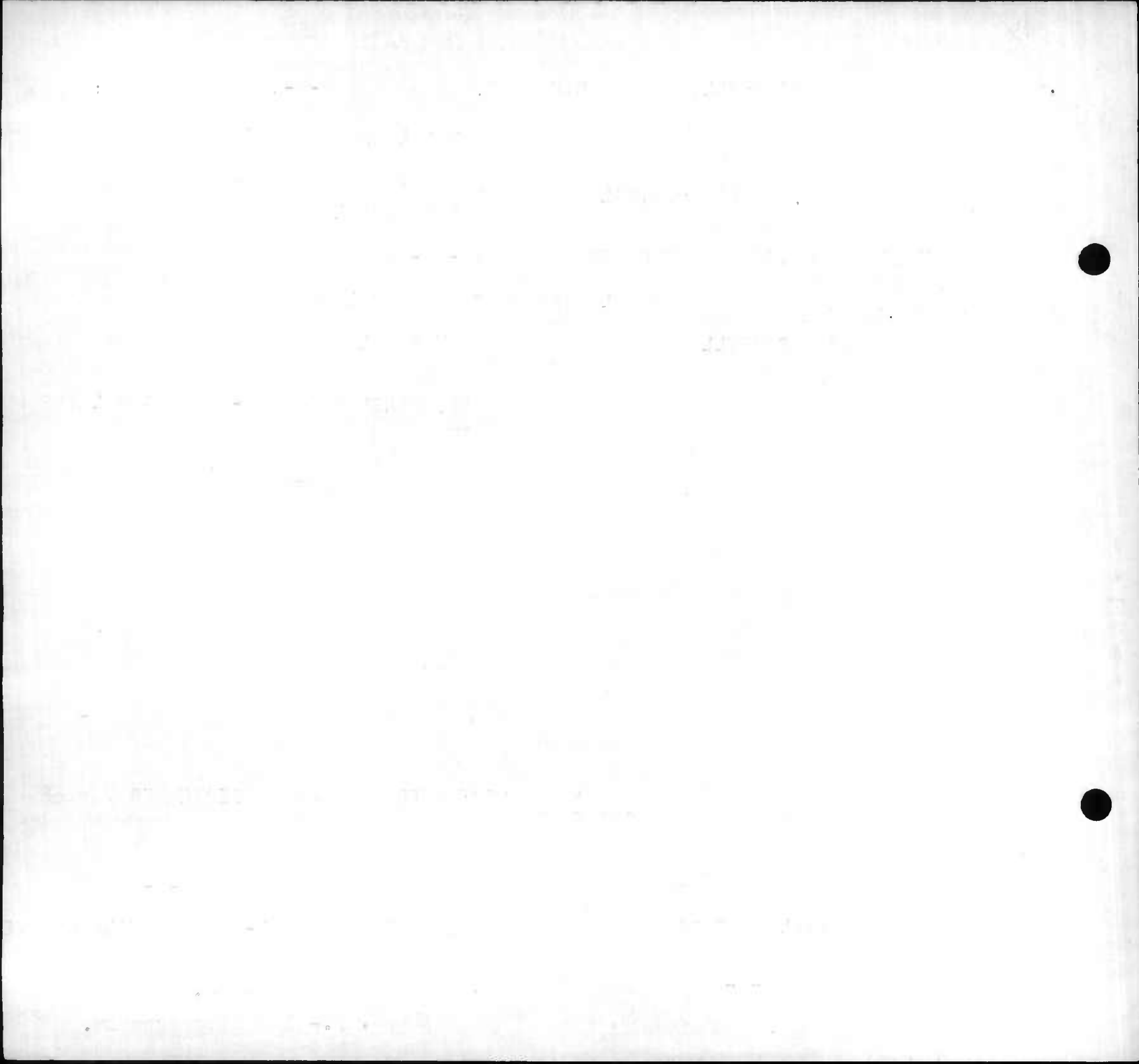
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|--|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 66 09049 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09049 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| POCH, JOSEPH EDWARD | | 9-7-66 | | 6:20A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | A. STATE MARYLAND B. COUNTY HOWARD | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY | | | |
| | | D. STREET ADDRESS (If rural, give location) TRIADELPHIA ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 5-14-64 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME JOSEPH POCH | | | |
| 14. MOTHER'S MAIDEN NAME CELINA GILBERT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (Terminal) Bronchopneumonia (Terminal) (B) DUE TO Acute Leukemia Severe Pseudomonas Septicemia | | INTERVAL BETWEEN ONSET AND DEATH Aug 25 - Sept. 7/66 Aug 25 - Sept 7/66 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 25 19 66 to SEPTEMBER 7 19 66 that (I) <u>we</u> last saw the deceased alive on SEPTEMBER 7 19 66 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cora P. Grellano | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 7, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 9, 1966 | | 24C. NAME of CEMETERY or CREMATORY St. Louis | |
| 24D. LOCATION (City, town, or county) (State) Clarksville, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Harry H. Witzke, 321 Columbia Pike Ellicott City, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

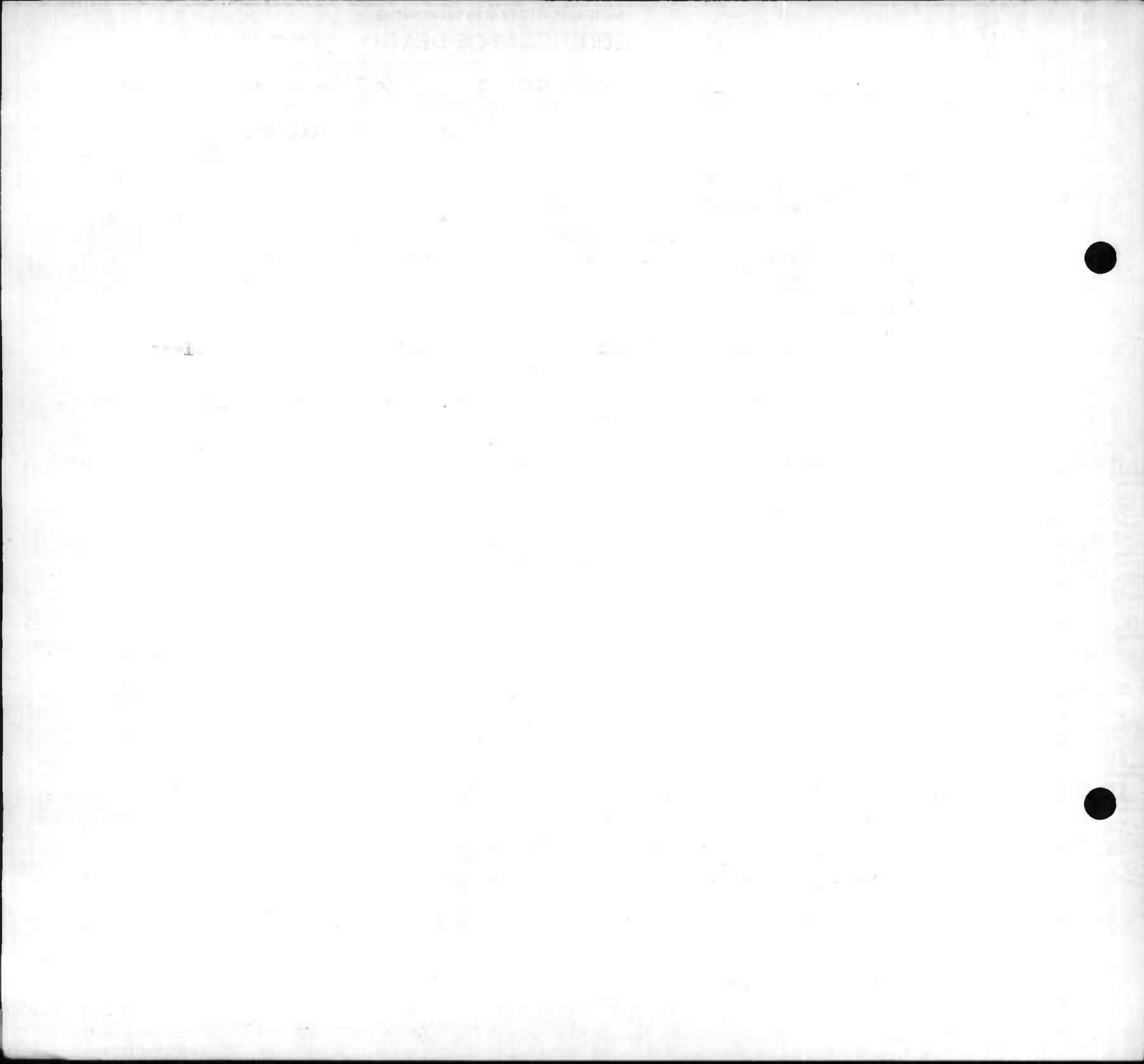
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09050 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 66 09050 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. 66 09050 | |
| 1. NAME OF DECEASED (Type or Print) SAFFELL, NORMAN G. | | | 2. DATE AND HOUR OF DEATH 9-7-66 2:50A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 7 53-00 D. STREET ADDRESS (If rural, give location) 3153 JEFFLAND ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-12-07 | 9. AGE (In years lost birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME JOHN SAFFELL | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 214 03 2662 | | 17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction, Inferior Acute | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 6 19 66 to SEPTEMBER 7 19 66 , that (I) (we) last saw the deceased alive on SEPTEMBER 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-7-66 | |
| 23C. PHYSICIAN'S NAME (Type) EWALDO WEISS | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL-CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY OR CREMATORY Lakeview Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, F. D. - 4101 Edmondson Av. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|--|--|--|---|
| BIRTH NO. M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09051 | |
| 1. NAME OF DECEASED (Type or Print) EDITH Amelia | | UPPERCUE | | 2. DATE AND HOUR OF DEATH 1st AM Sept 7, 1966 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House of the Pines Belair 90 5837 Belair Rd Balt 36 Md | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Overlea Mills D. STREET ADDRESS (If rural, give location) 5100 Kenwood Avenue 6 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 28 Feb 1878 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John Jacob Faupel | | 14. MOTHER'S MAIDEN NAME Amelia Christina Klees | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Grace Cunningham 517 Wilton Avenue | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Atherosclerotic Cardiovascular Dis. unkt. DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Fall of 1961 to 7 Sept 1966 , that (I) do last saw the deceased alive on 8-26 1966 and that in (my) do opinion death occurred on the date and hour and from the causes stated above. (I) do (did) not view the body after death. | | | | | |
| 23A. SIGNATURE John C. Hyle | | | | 23B. DATE SIGNED 9-7-66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. Hyle | | | | 23D. ADDRESS M.D. 7527 Belair Rd Balt 36 Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/1966 | | 24C. NAME of CEMETERY or CREMATORY Garden of Faith Cemetery | |
| 24D. LOCATION Baltimore County, Maryland | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. [illegible] | | 25C. FUNERAL DIRECTOR Wm. J. [illegible] + Sons | |



Released on APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|----------------------------------|--|-------------------------|---|
| 66 09052 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09052 | |
| BIRTH NO. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Lida Helen Bright | | | 9/7/66 9:20 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Mayland Gen. Hosp. | | | Mayland Baltimore 27-15 | | |
| 5. SEX | | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) |
| F | | | W | | Widowed |
| 8. DATE OF BIRTH | | | 9. AGE (In years last birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 3/6/80 | | | 86 | | Housewife |
| 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME |
| Mayland | | | U.S.A. | | W. McCulloh Butts |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| May Jewelllyn | | | No | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Link | | | Hospital Chart | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| II | | | (A) DUE TO | | 4 days |
| ANTECEDENT CAUSES | | | (B) DUE TO | | 4 days |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO | | 6 wks. |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Anterosclerotic heart disease | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 2 None | | | | | Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| 7/31/66 6PM? | | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | Fell |
| 22. I certify that (I) (this hospital) attended the deceased from 7/31 1966 to 9/7 1966, that (I) (we) last saw the deceased alive on 9/7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Peter B. Mac Murray | | | 9/7/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| | | | M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| Burial | | 9/10/1966 | Loudon Park Cemetery | | Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | |
| SEP 8 1966 | | Robert E. Fairbank | Wm. J. Fairbank & Sons Balto., Md. North & Pa. Aves. | | |

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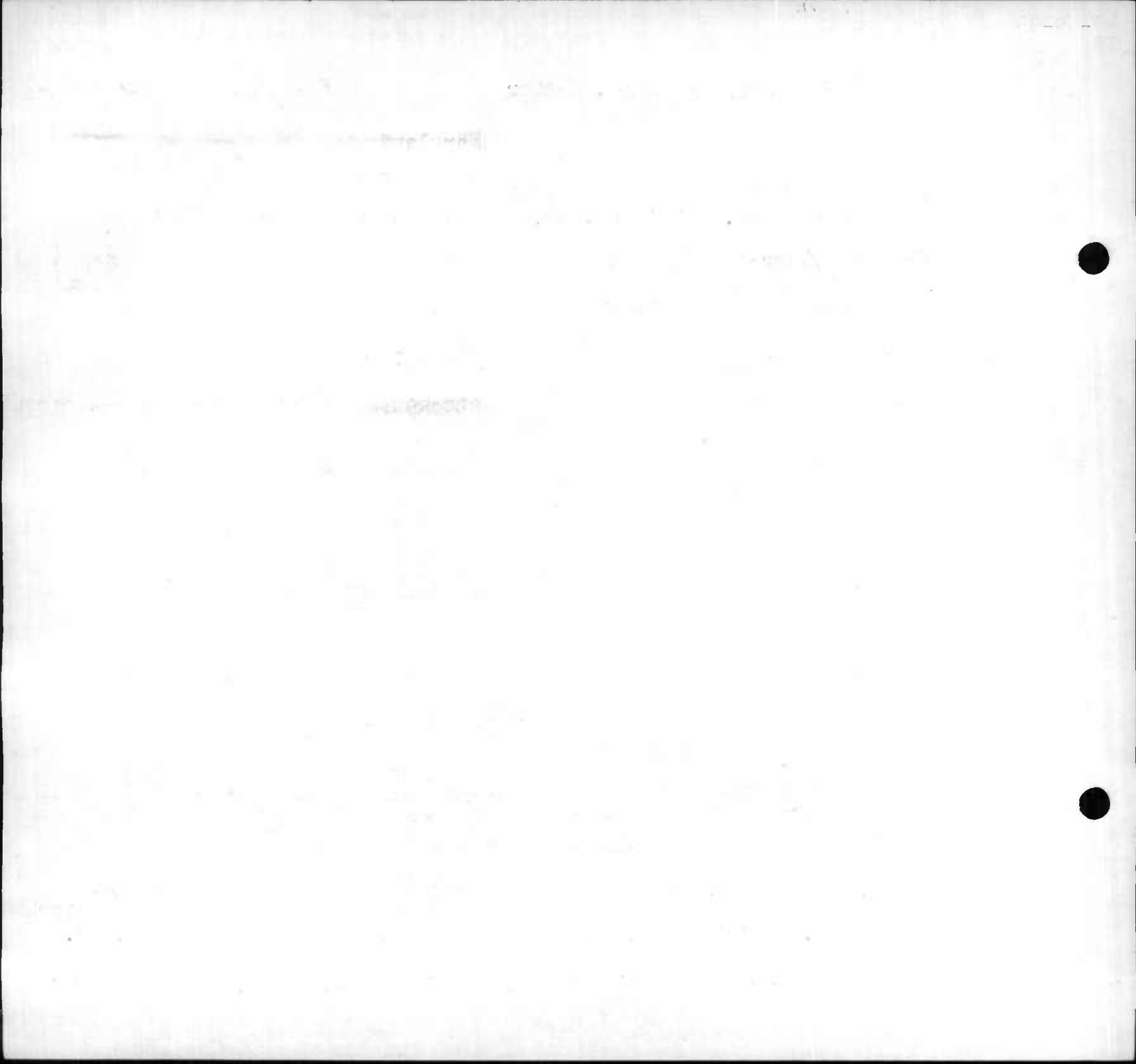
Light Green Leaflet

47-59-93
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09053 | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. 66 09053 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) BABY GRL MURRY, Esther | | | 2. DATE AND HOUR OF DEATH 8/31/66 10:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 21224 4940 Eastern Ave. Baltimore, Md. | | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-47 D. STREET ADDRESS (If rural, give location) 2105 KOKO LANE 21216 | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH 8/30/66 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: Hours: Min. 23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | |
| 13. FATHER'S NAME C.L. MURRY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | 14. MOTHER'S MAIDEN NAME ESTER JEANNETT | | |
| 16. SOCIAL SECURITY NO. — | | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PREMATURITY | | | INTERVAL BETWEEN ONSET AND DEATH 29 hrs | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) — | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (1) (this hospital) attended the deceased from 8/30/66 19 66 to 8/31 19 66 , that (1) (we) lost saw the deceased alive on 8/31 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel Patterson M.D. | | | 23B. DATE SIGNED 8/31/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Daniel Patterson M.D. | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 9-1-66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland 21224 | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | | |
| 25B. NAME OF REGISTRAR Edna E. Taylor | | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | | | |

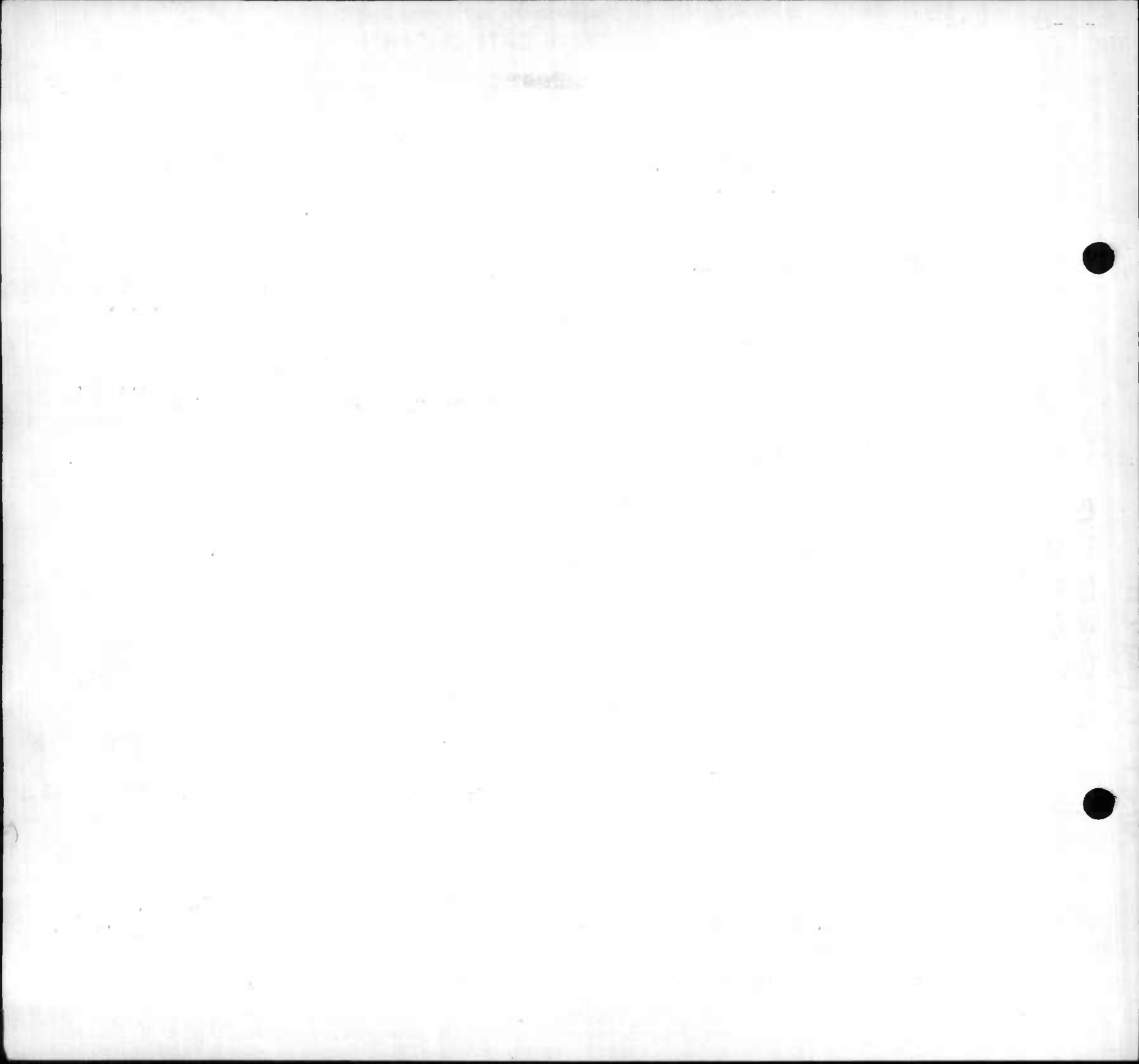


47-61-13
VLB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 09054 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09054 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Gloria Means</i> BABY GIRL | | 2. DATE AND HOUR OF DEATH <i>9-1-66</i> 12:15 P. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 EASTERN AVE. BALTO., MD. 21224 <i>Baltimore City Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1533 N. EDEN ST. 21213 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED SINGLE | 8. DATE OF BIRTH <i>9-1-66</i> | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>10 10</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 13. FATHER'S NAME HUGH | | 14. MOTHER'S MAIDEN NAME <i>MEANS, Gloria Ann.</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT RECORDS-BCH 4940 EASTERN AVE. BALTO., MD. 21224 | |
| 18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) IMMATURITY | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/1 2:05 AM</i> 19 <i>66</i> to <i>9/1/ 12:15 PM</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/1</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>L. Risenberg</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-1-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) L. RISEMBERG | | M.D. 23D. ADDRESS <i>Balti. City Hospital</i> | | 23E. ADDRESS 4940 EASTERN AVE. BALTO., MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 9/5/1966 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | |

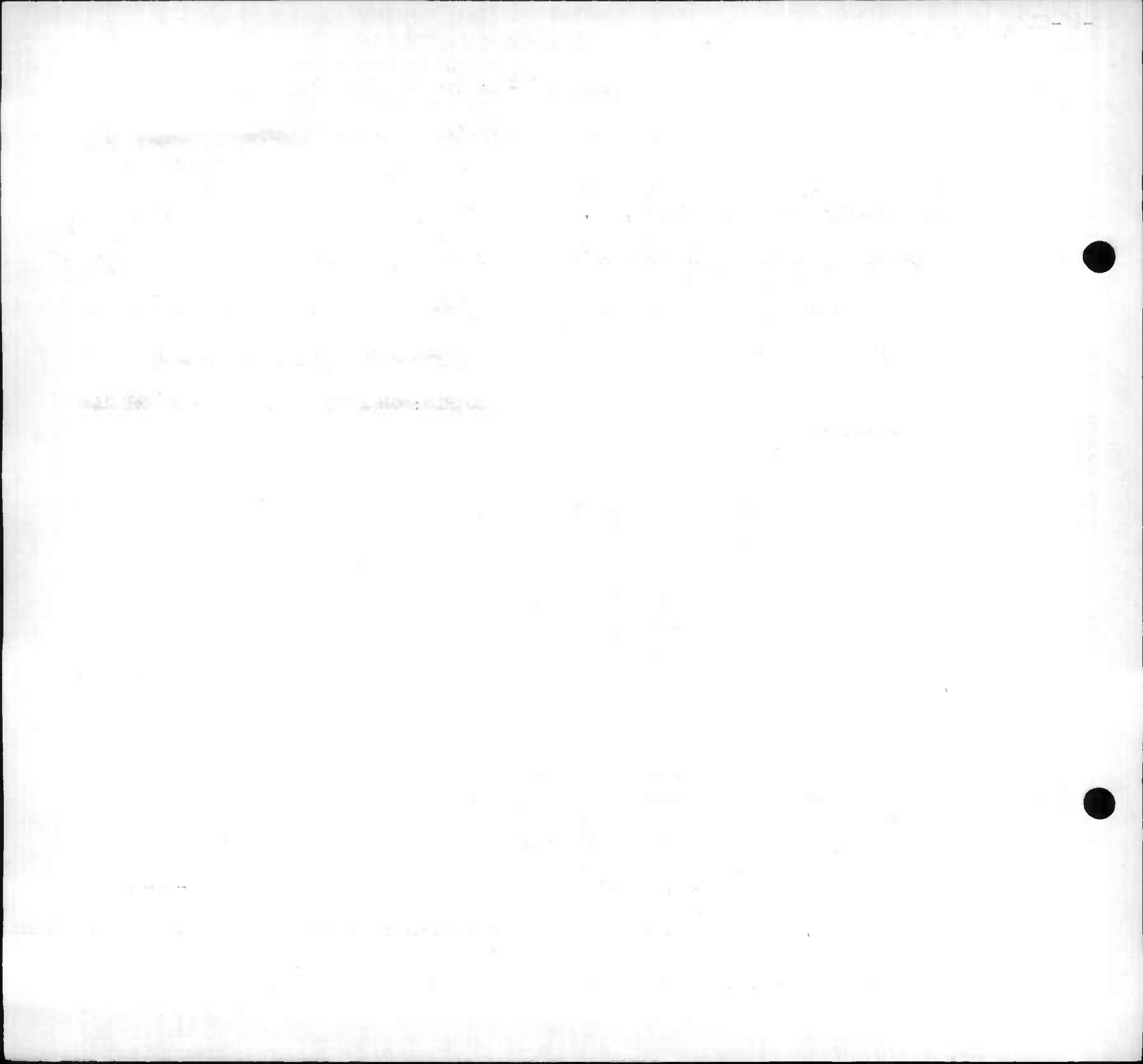


47-60-01
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

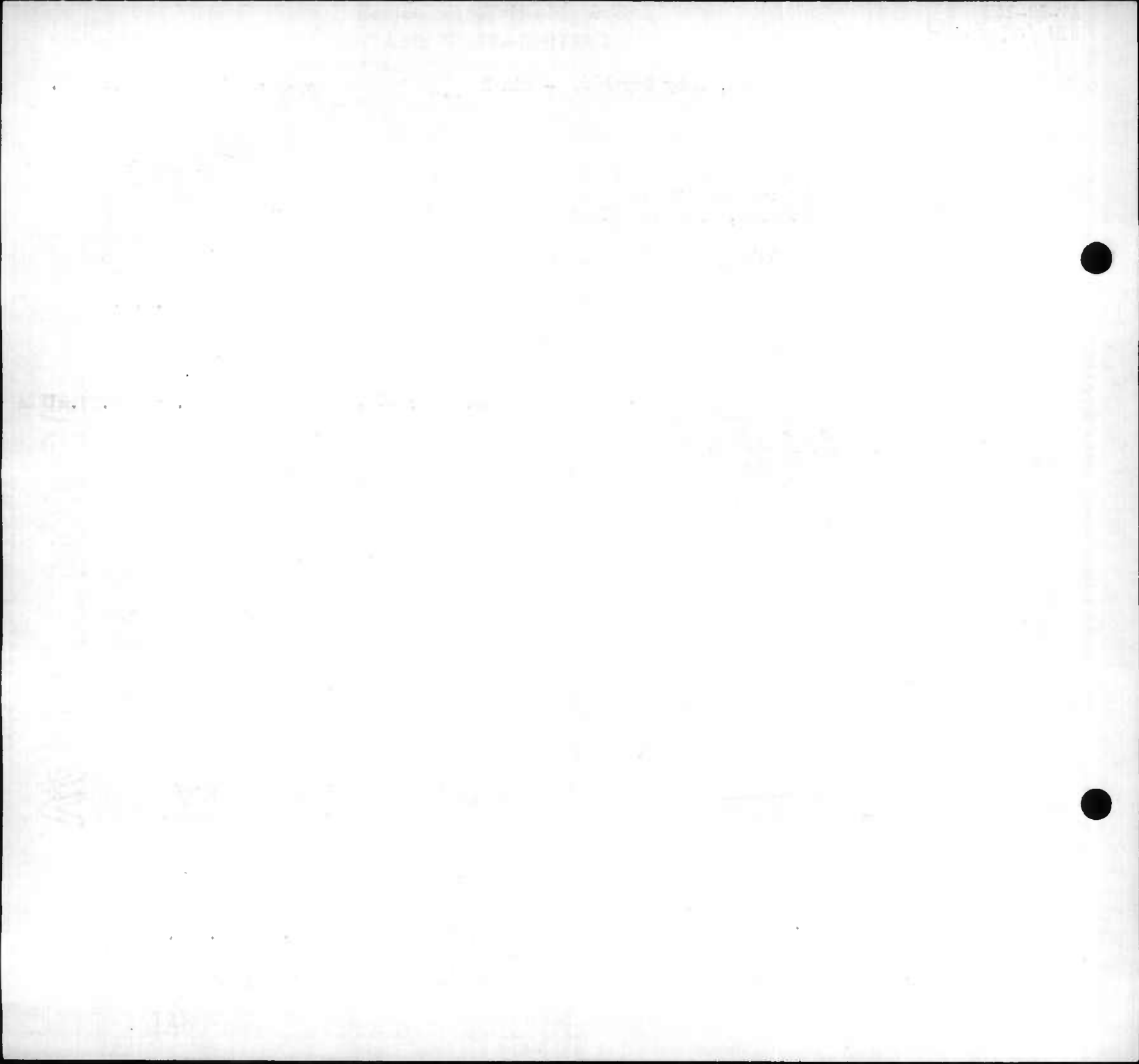
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09055 | |
|--|-------------------------|--|------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | Twin "B" | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BABY GRL CRAWFORD | | Betty | | 2 15 PM 18/31/66 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Md. 21224 | | A. STATE MARYLAND | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 9-08 | |
| | | D. STREET ADDRESS (If rural, give location) 1026 E. NORTH AVE. | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 8/31/66 | 9. AGE (In years (last birthday)) 9 | If Under 1 Yr. Months Days 5 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME NONE GIVEN | | 14. MOTHER'S MAIDEN NAME BETTY CRAWFORD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. 773.5 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO premature | | 9 hrs & 5 mins | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Respiratory distress | | 2 8 5 | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 4 (this hospital) attended the deceased from 8/31 19 66 to 8/31 19 66 , that 4 (we) last saw the deceased alive on 8/31 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 4 (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Mo. S. Haddad | | | | 23B. DATE SIGNED 8-31-66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. MUNZER HADDADIN | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 9/5/1966 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|--------------------------|--|------------------------------|
| 47-62-24 NIW | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09056 4 | |
| BIRTH NO. 66-18235 66 09056 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MOORE, Baby Boy Mary -Twin B | | 9/2/66 2:35 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 851 George Street - 21201 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| MALE | NEGRO | NEVER MARRIED | 9/2/66 | | 5 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| EARL | | | MARY SCURRY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. 776X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Immaturity | | 5 hours. | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (the deceased) attended the deceased from 9/2/19 66 to 9/2/19 66, that (I) lost saw the deceased alive on 9/2/19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| <i>L. Risenberg</i> | | | | 9/2/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| L. RISEMBERG | | BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Cremated | | 9/5/1966 | | Baltimore City Hospitals | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 8 1966 | | Robert E. Farley | | HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 09057

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MOORE, Baby Girl Mary -Twin A

2. DATE AND HOUR OF DEATH

9/2/66

7: P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

851 George Street - 21201

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED

8. DATE OF BIRTH

9/2/66

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

EARL

14. MOTHER'S MAIDEN NAME

SCURRY, MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., Balto, Md. 21224

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Immaturity
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

10 hours

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from 9/2 1966 to 9/2 1966, that (I) (we) lost saw the deceased alive on 9/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L. RISEMBERG

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/2/66

23C. PHYSICIAN'S NAME (Type)

L. RISEMBERG

23D. ADDRESS

BALTIMORE CITY HOSPITALS

M.D.

4940 Eastern Avenue, Balto, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremated

24B. DATE

9/5/1966

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 8 1966

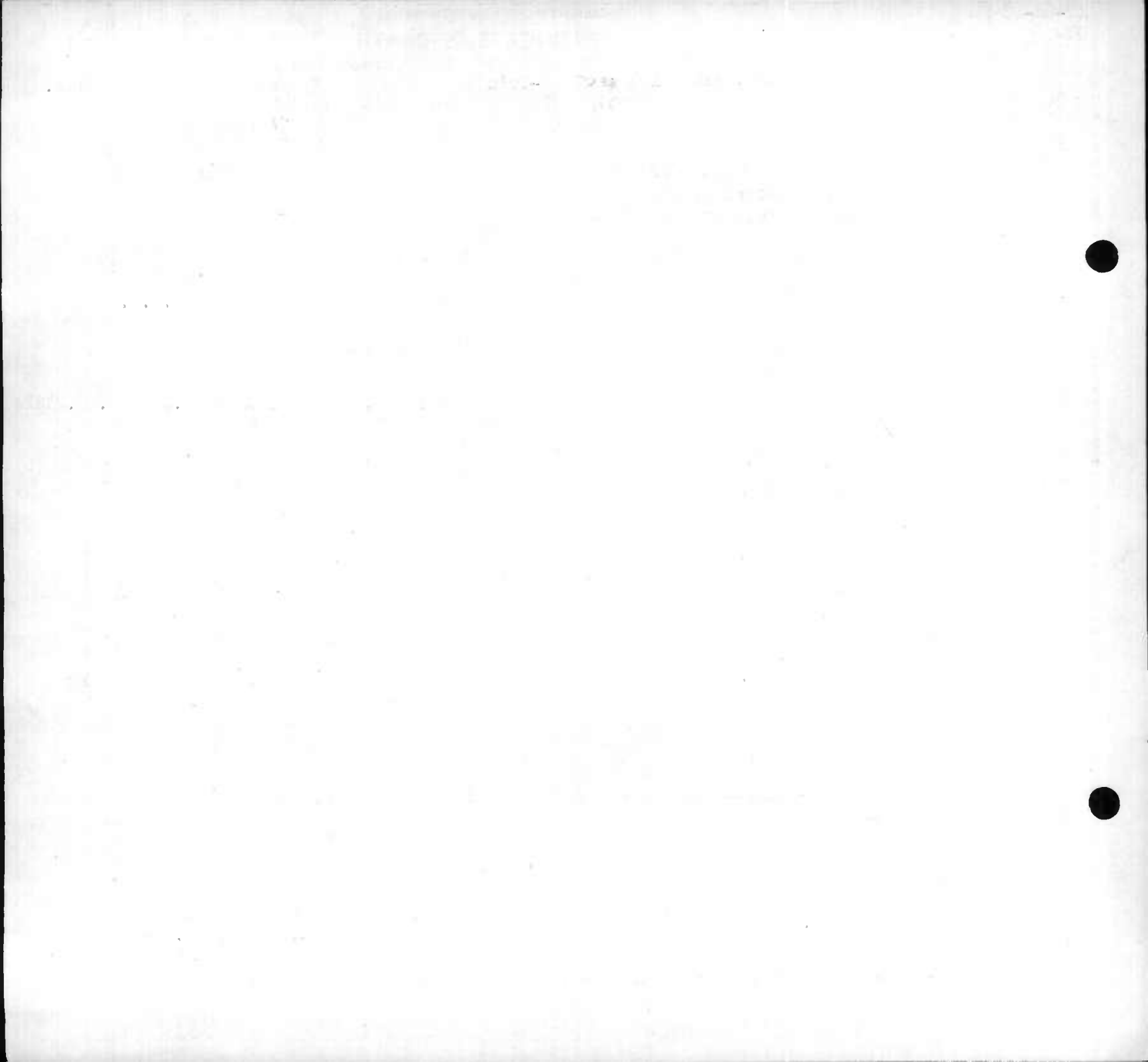
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

HOSPITAL DISPOSAL

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|--|---------------------------------|--|---|
| BIRTH NO. 66 09058 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09058 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MURRAY JOHN WESLEY | | 2. DATE AND HOUR OF DEATH SEPTEMBER 1 1966 4:15P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL | | A. STATE MD B. COUNTY Prince George | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) LAUREL | | | |
| | | D. STREET ADDRESS (If rural, give location) 383 MAIN ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-22-94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant | | 10B. KIND OF BUSINESS OR INDUSTRY own store | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME JOHN Bedford Murray | | 14. MOTHER'S MAIDEN NAME ALICE RUCKS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE. | |
| 18. 430.01 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) PNEUMONIA | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) GENERALIZED ARTERIOSCLEROSIS | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUG. 6 19 66 to SEPT 1 19 66 , that (I) (we) last saw the deceased alive on SEPT 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE JUAN J. CABRERA M.D. | | | | 23B. DATE SIGNED 9-1-66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Juan J. Cabrera | | | | 23D. ADDRESS CATON AND WILKENS AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/3/66 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memory Park | |
| 24D. LOCATION (City, town, or county) Prince George - Md. | | 24E. STATE Md. | | 24F. ADDRESS Laurel, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Walter St. Bonifacio | |

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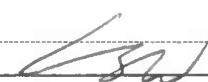
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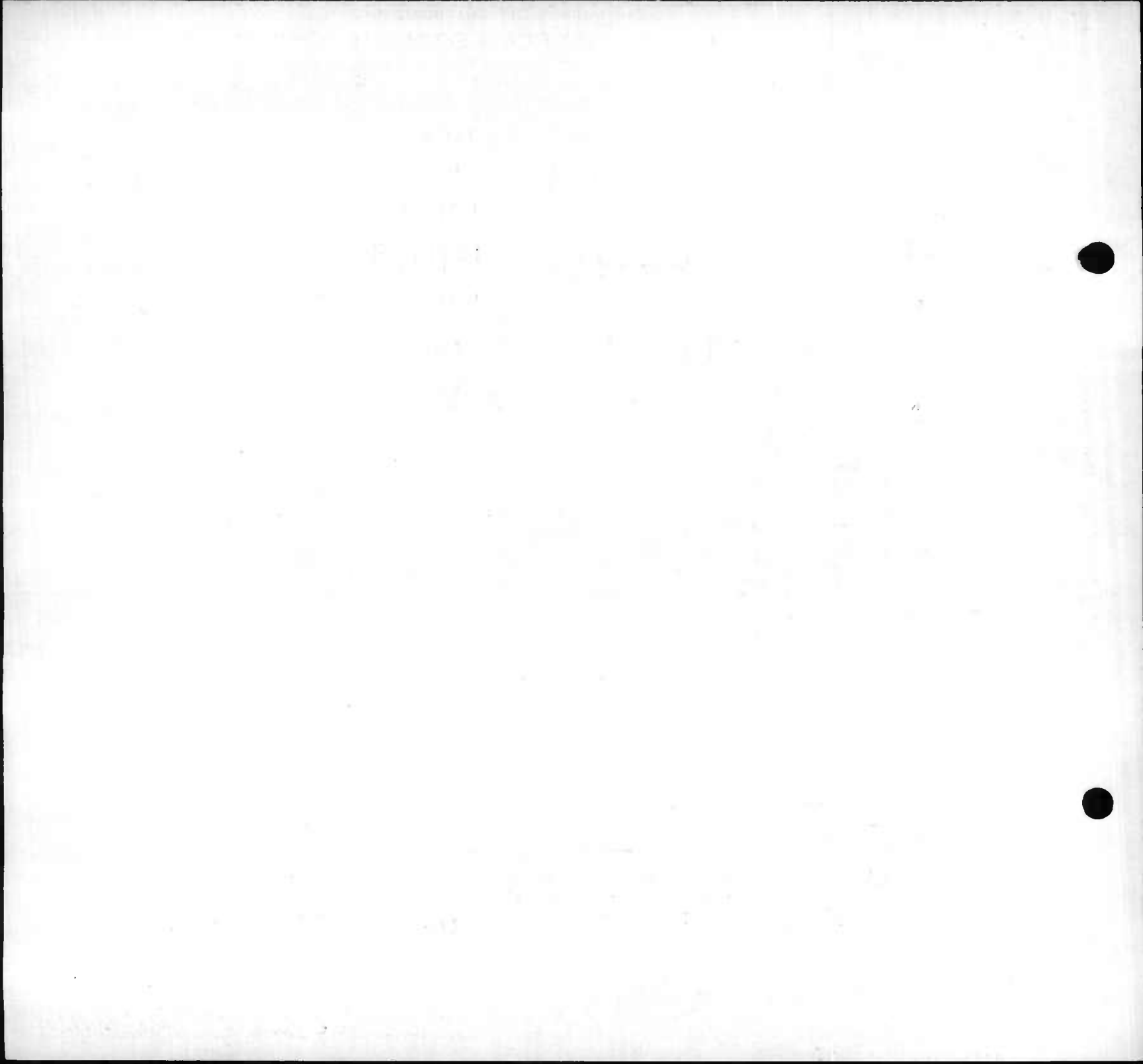
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

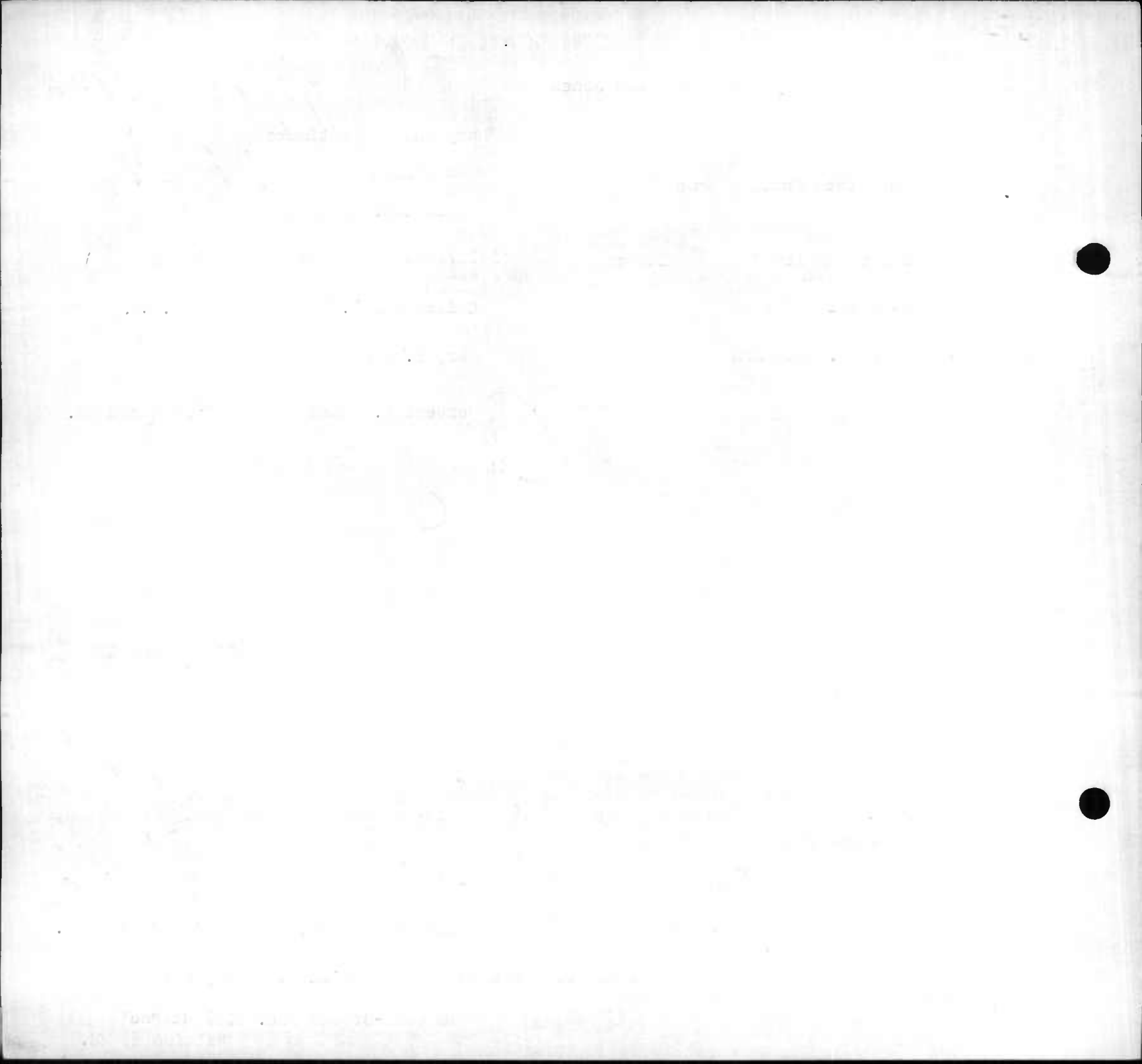
| BIRTH NO. 66 09059 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 09059 | |
|---|--------------|---|--|--|--|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FLAHERTY MINNA LEE | | 2. DATE AND HOUR OF DEATH 9/6/1966 11 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP 44 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 11-02 D. STREET ADDRESS (If rural, give location) 101 W. MONUMENT Street | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 12/17/93 | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME HENRY STAYLOR | | | | 14. MOTHER'S MAIDEN NAME CARRIE THORPE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-03-26 | | 17. INFORMANT THORPE, STAYLOR ADDRESS 82-D 1604 LOCH NESS RD. BALTO. MD 21204 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.117-15571 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH A. SEVERE ASCVD & MITRAL STENOSIS B. CARCINOMA ? ANGIOMA ? VATER C.  | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 19/2/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED choledochal - duodenostomy | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-22-1966 to 1966, that (I) (we) last saw the deceased alive on 9/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Giselle T. Bretz M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Giselle BRETZ M.D. | | | | 23D. ADDRESS Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEPT 9 1966 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR R. E. J. J. J. | | 25C. FUNERAL DIRECTOR WM. COOK BROOKS TOWSON | | ADDRESS 1080 YORK ROAD TOWSON, MD. 21204 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------|---|--|--|---|--|--|--|--------------------------------------|
| BIRTH NO. 66 09060 | | | | | REGISTERED NO. 66 09060 | | CITY OF BALTIMORE | | |
| 1. NAME OF DECEASED (Type or Print) Mary Bruce Nicolson Jones | | | | | 2. DATE AND HOUR OF DEATH 9/7/66 11:00 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION: Long Green Nursing Home (If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 1526 Bolton Street | | | | |
| 5. SEX: Female | 6. RACE: White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed | 8. DATE OF BIRTH: 5/25/1883 | 9. AGE (In years last birthday): 83 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | | 11. BIRTHPLACE (State or foreign country): Chicago, Ill. | | 12. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 13. FATHER'S NAME: James A. Nicolson | | | | | 14. MOTHER'S MAIDEN NAME: Mary B. Campbell | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No | | | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: Herbert R. Jones ADDRESS: 1242 Ramblewood Rd. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH: Cancer of Breast INTERVAL BETWEEN ONSET AND DEATH: 170 X I | | | | | 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 21A. DATE OF OPERATION: 0 | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED: | | 22A. AUTOPSY? (Yes or No): | | 22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner): | | | 23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): | | 23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): | | | | |
| 24A. TIME OF INJURY (Approx.): | | | 24B. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 24C. HOW DID INJURY OCCUR?: | | | | |
| 25. I certify that (I) (this hospital) attended the deceased from Dec 7 1966 to Sept 7 1966, that (I) (we) last saw the deceased alive on Sept 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 26A. SIGNATURE: William Helfrich | | | | | 26B. DATE SIGNED: 9/8/66 | | | 26C. PHYSICIAN'S NAME (Type): William Helfrich | |
| 27A. ADDRESS: 5006 Roland Avenue | | | | | 27B. ADDRESS: Baltimore, Md. | | | | |
| 28A. BURIAL CREMATION, REMOVAL (Specify): | | | 28B. DATE: SEP 8 1966 | | 28C. NAME OF CEMETERY or CREMATORY: Loudon Park Cemetery | | 28D. LOCATION: Baltimore, Maryland | | |
| 29A. DATE REC'D BY HEALTH DEPT.: | | | 29B. NAME OF REGISTRAR: Wm Cook-Brooks Inc. | | 29C. FUNERAL DIRECTOR: 1217 St Paul | | 29D. ADDRESS: Baltimore, Md. | | |



1
C-620

66 09061

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09061

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Brenda K. Crook

2. DATE AND HOUR PRONOUNCED DEAD

9/5/66 4:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

422 Tuxedo St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

9/29/58

9. AGE (In years last birthday)

7

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Crook

14. MOTHER'S MAIDEN NAME

Dorothy Williston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Robert Crook (same as #4)

18. E830.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Craniocerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

422 Tuxedo St.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 9 5 66 2:40p.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? struck by pde, which had been struck by auto.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/6/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/8/66

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

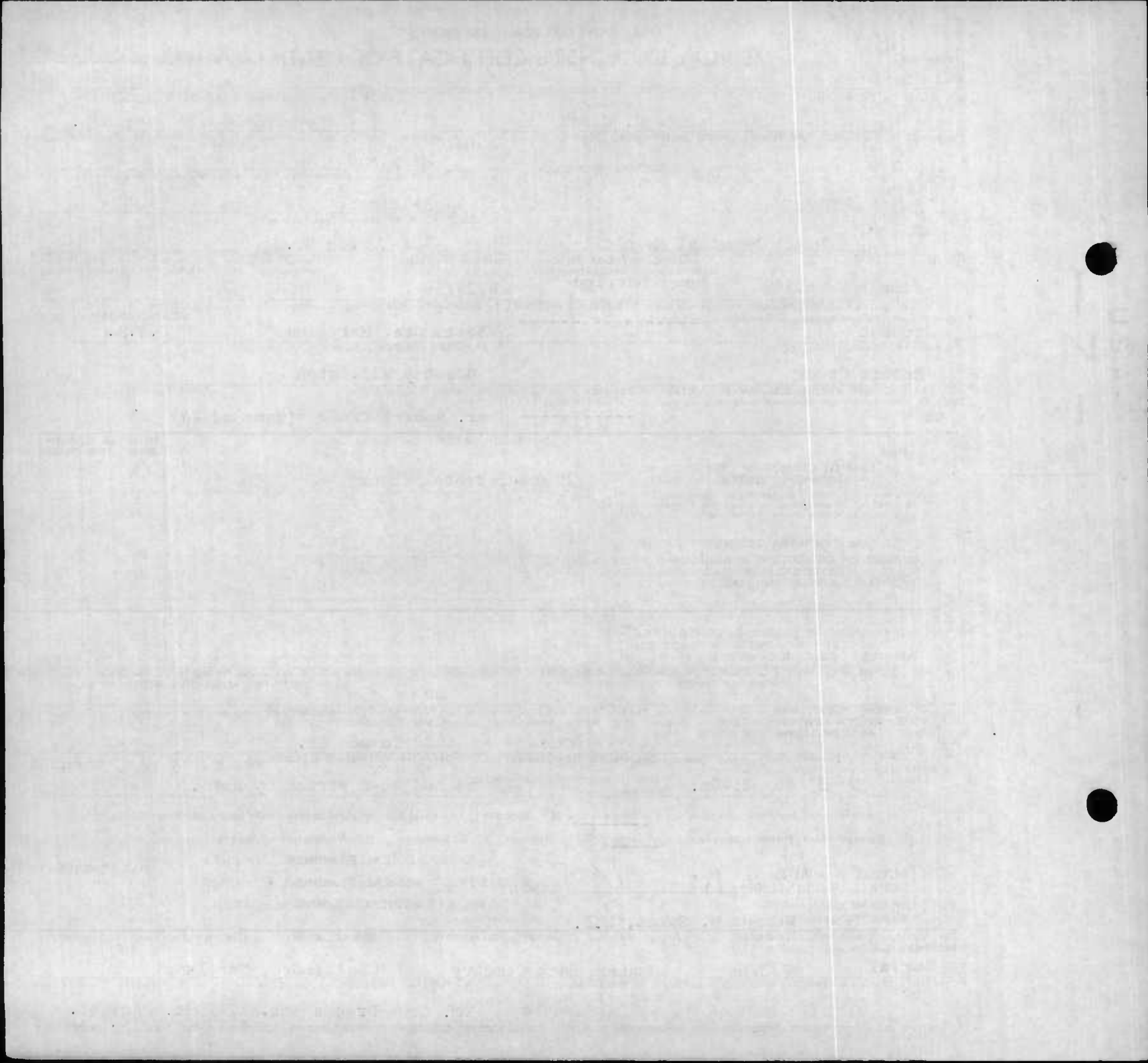
SEP 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St. Baltimore, Md. 21202



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-632 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09062 | |
|--|--------------------------------|---|--|---|--|
| IRTH NO. 66 09062 M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>HERMAN FRITCH</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 6, 1966</u> <u>11:15 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>House of Pines</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5837 Belair Road</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 26, 1876</u> | 9. AGE (In years last birthday) <u>90</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (State or foreign country) <u>Indiana</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Louis Fritch</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mellissa Vaughan</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>2/5/99-2/4/02</u> | | 16. SOCIAL SECURITY NO. <u>213-26-4826</u> | | 17. INFORMANT <u>Ft. Howard V.A. Records</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Acute Circulatory Collapse</u> DUE TO (B) <u>Acute Myocardial Infarction</u> DUE TO (C) <u>Arteriosclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>May 20</u> 19<u>66</u> to <u>Sept 6</u> 19<u>66</u>, that (1) was last saw the deceased alive on <u>Sept. 1</u> 19<u>66</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) We (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alton B Bradley</u> | | | | 23B. DATE SIGNED <u>9/6/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Alton B Bradley</u> | | | | 23D. ADDRESS <u>8521 Loch Raven Blvd.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/9/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park National Cem., Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 8 1966</u> | | 25B. NAME OF REGISTRAR <u>Alton B Bradley</u> | | 25C. FUNERAL DIRECTOR <u>Alton B Bradley</u> | |

1
J-520

66 09063

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09063

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIJAH EARL JONES

2. DATE AND HOUR PRONOUNCED DEAD

August 29, 1966

8:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

100 blk W. Dover Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

00-00

D. STREET ADDRESS (If rural, give location)

Unknown

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov. 27, 1924

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Walter Jones

14. MOTHER'S MAIDEN NAME

Julia Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

two

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

226 Broad St.

Willis & Ballard Funeral Home, New Bern, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Blunt impact to abdomen with
laceration of mesentery and hemo-
peritoneum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

UNKNOWN

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8-28-66 or 8-29-66

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

UNKNOWN

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 7, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/9/66

23C. NAME of CEMETERY or CREMATORY

Bridgeton Cemetery

23D. LOCATION

(City, town, or county)

Craven Co., N.C.

24A. DATE REC'D BY HEALTH DEPT.

SEP 8

1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

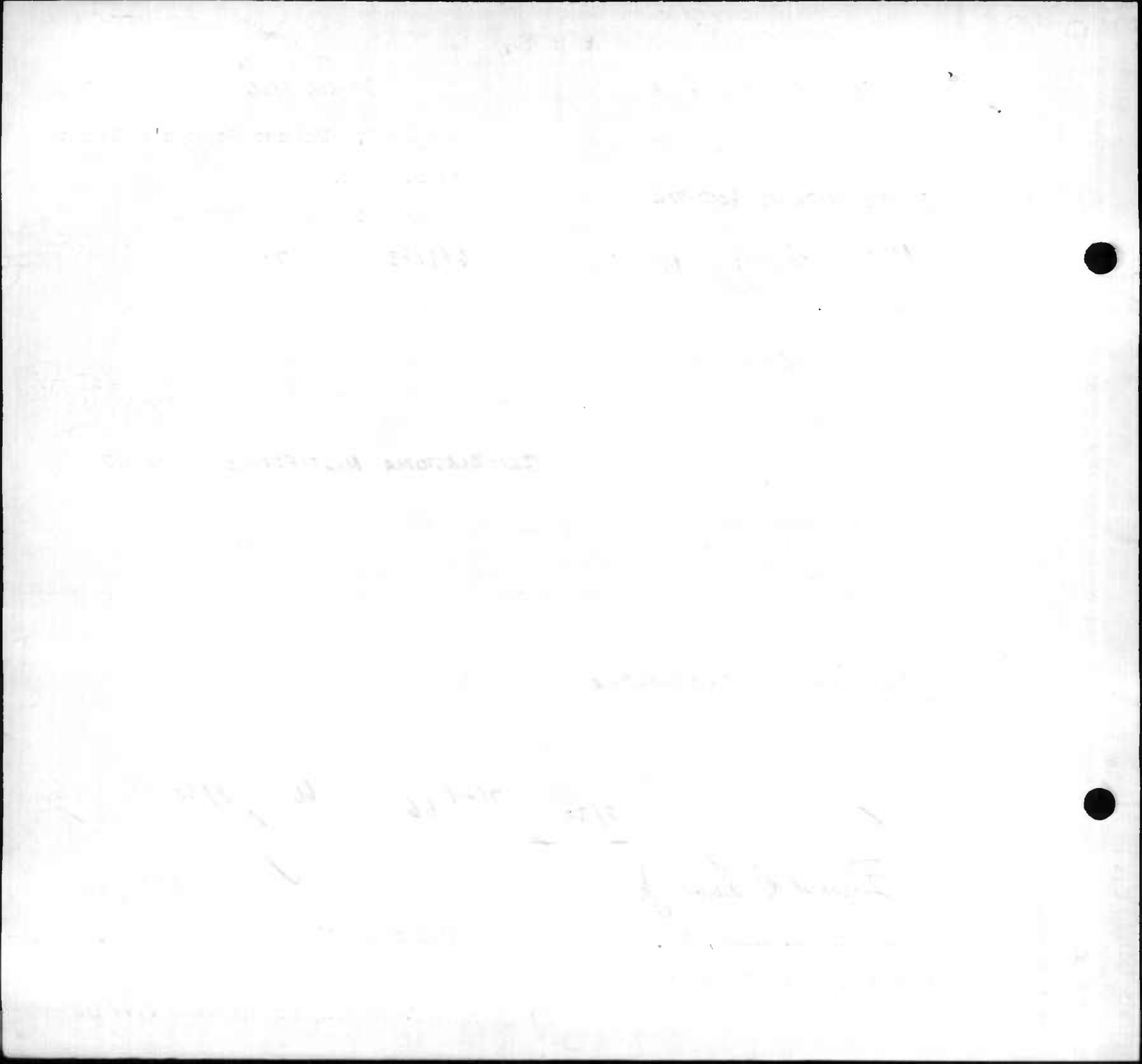
Wm. Cook-Brooks, 1217 St. Paul St.
Baltimore, Maryland

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------|---|-------------------------|--|--|
| BIRTH NO. 66 09064 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09064 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BOWERS, ALLIE R. | | 2. DATE AND HOUR OF DEATH 30 AUG 1966 12:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Prince George's County C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hyattsville D. STREET ADDRESS (If rural, give location) 4410 Ogelthorpe Street | | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/3/93 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER & OWNER | | 10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Tivus Bowers | | 14. MOTHER'S MAIDEN NAME Mary UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213 428 029A | | 17. INFORMANT ADDRESS WILLIAM T. BOWERS 3008 CREST AV. CHEVERLY, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) GLIOBLASTOMA MULTIFORME | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 MO | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO | | (B) DUE TO | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 2/28/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GLIOBLASTOMA | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/24 19 66 to 8/30 19 66, that (I) (we) last saw the deceased alive on 8/30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward R. Laws Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8/30/66 | |
| 23C. PHYSICIAN'S NAME (Type) Edward R. Laws, Jr. | | 23D. ADDRESS Johns Hopkins Hopkins 601 N. Broad- | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3 SEPT 1966 | | 24C. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | |
| 24D. LOCATION (City, town, or county) BLADENSBURG, MARYLAND | | 24E. FUNERAL DIRECTOR W.W. Chambers | | 24F. ADDRESS Bo. Riverdale, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09065 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09065 | |
|--|---------|--|---|--|-----------------------------|
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) | | |
| | | | SCHANINGER, HOWARD EDWARD | | |
| 2. DATE AND HOUR OF DEATH | | | SEPTEMBER 6 th 1966 10:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| THE UNION MEMORIAL HOSPITAL | | | MD BALTIMORE 12-02 | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) | | | THE CHARLES APTS. 3333 N. CHARLES ST. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | W | MARRIED | 03/03/95 | 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| OWNER | | | MARYLAND | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| B.T. HOWARD CO. (CHEMICAL) | | | U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| HENRY O. SCHANINGER | | | ADELE HERZOG | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| YES WWI | | | 214-03-6840A | | |
| 17. INFORMANT | | | ADDRESS | | |
| HOWARD SCHANINGER | | | AS 7N #4. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | (A) Myocardial Infarction | | |
| ANTECEDENT CAUSES | | | (B) Coronary arteriosclerosis | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT. 3 rd 1966 to SEPT 6 th 1966, that (I) (we) last saw the deceased alive on SEPT 6 th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Roy Stuart Patten | | | | SEPT. 6 th 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ROY STUART PATTEN | | | | THE UNION MEMORIAL HOSPITAL BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/10/1966 | | Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Baltimore, Maryland | | H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 8 1966 | | H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto. 12, Md. | |

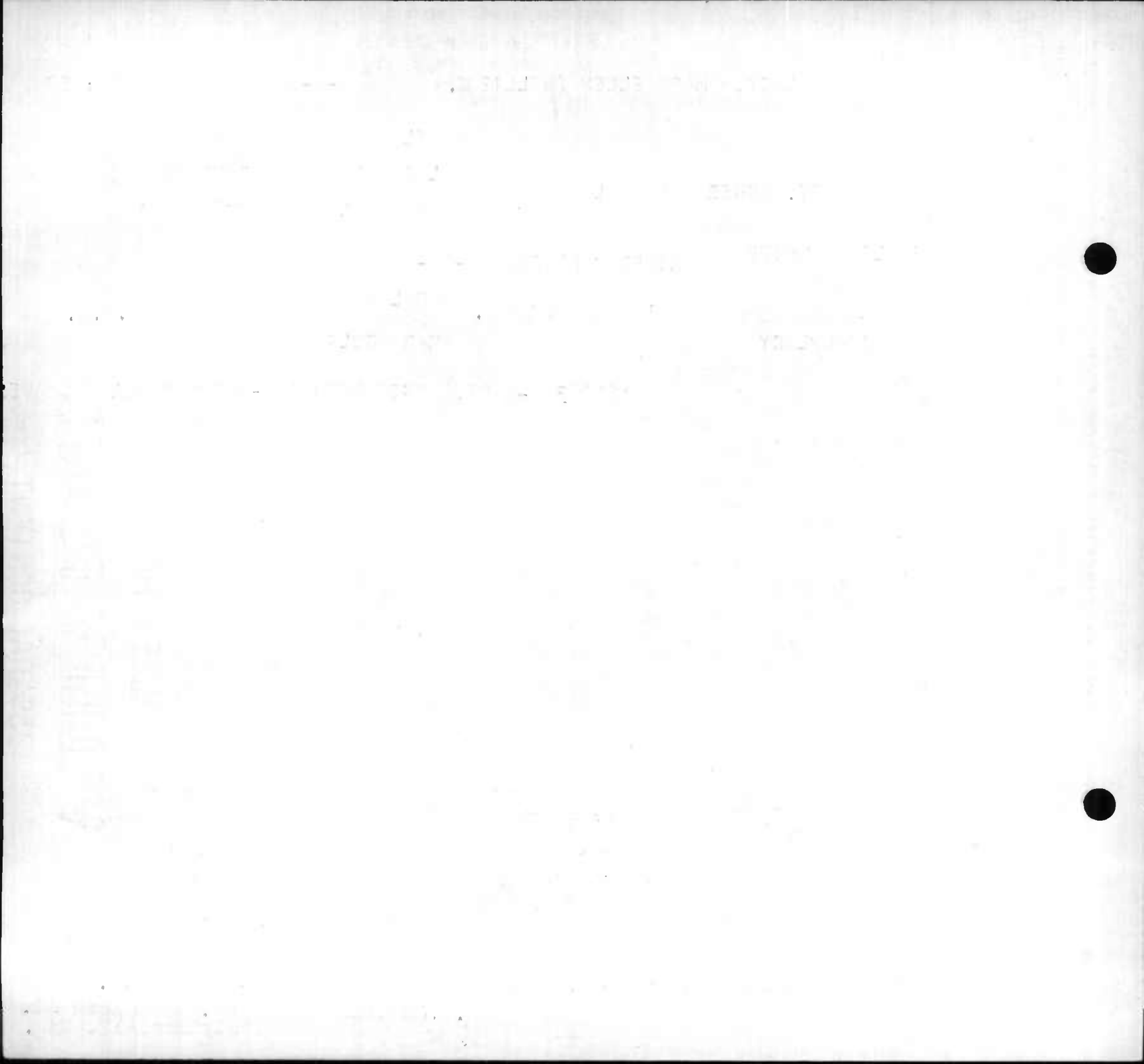
1. The first part of the report is a general statement of the purpose and scope of the study.

2. The second part of the report is a description of the methods used in the study.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

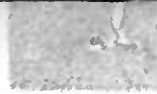
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|--|--|--|---|--|--|-----------------------------------|--|
| 66 09066 CERTIFICATE OF DEATH | | | | | Registered No. 66 09066 | | | | |
| BIRTH NO. 66 09066 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) LACY, MARY ELLEN (NELLIE K.) | | | | | 2. DATE AND HOUR OF DEATH 9-6-66 11:05P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 18 | | | | |
| D. STREET ADDRESS (If rural, give location) 2723 MARYLAND AVENUE | | | | | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 8-10-87 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Secretary | | | 10B. KIND OF BUSINESS OR INDUSTRY Allied Chemical Co. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME JOHN LACY | | | 14. MOTHER'S MAIDEN NAME MARY COLGAN | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NUMBER 215107398-A | | | 17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS AVE. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE DILATATION OF THE HEART MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 4 1966 to SEPTEMBER 6 1966, that (I) (we) last saw the deceased alive on SEPTEMBER 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Romualdo R. Dator, M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED Sept. 7, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Romualdo R. Dator | | | | | 23D. ADDRESS St. Agnes Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/1966 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09067 | |
| BIRTH NO. 66 09067 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Delbert Kenneth Wilson | | 2. DATE AND HOUR OF DEATH Sept. 7, 1966 3: 45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 412 S. Stricker Street | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep. | 8. DATE OF BIRTH 5/4/18 |
| 9. AGE (In years last birthday) 48 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipkeeper | 11. BIRTHPLACE (State or foreign country) Pa. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Ed. Wilson | |
| 14. MOTHER'S MAIDEN NAME Laura Dhiel | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. 208-07-5664 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pyelonephritis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchopneumonia Carcinoma of lung | | INTERVAL BETWEEN ONSET AND DEATH Days Days Mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 28 19 66 to Sept. 7 19 66 , that (I) (we) last saw the deceased alive on Sept. 7 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Michael E. Pelczar | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (R.) M.D. | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/10/66 | |
| 24C. NAME OF CEMETERY or CREMATORY Loudon PARK Cem | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Thomas J. Korry | | ADDRESS Balto Md | |



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D-630

66 09068

BALTIMORE CITY HEALTH DEPARTMENT

66 09068

BIRTH NO. 66-19791

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | |
|---|---------------------------|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) BABY GIRL DURRETT | | | 2. DATE AND HOUR PRONOUNCED DEAD 8-21-66 12:20 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL - DOA | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13-02 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2347 Eutaw Place | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 5 ? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. CAUSE OF DEATH E-926.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Asphyxia (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Suffocation in a blanket (B) DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-7-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Automobile | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Enroute to Baltimore City Hospital | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-21-66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 23B. DATE 9-7-66 | | 23C. NAME of CEMETERY or CREMATORY Medical Examiner Office | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR City Morgue | |
| 24D. LOCATION (City, town, or county) (State) BALTO. Md. | | ADDRESS | | | |

VALENTIN FORMER

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66 09069

BALTIMORE CITY HEALTH DEPARTMENT

66 09069

BIRTH NO. 66-19937

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | |
|---|------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) NEWBORN UNKNOWN WHITE MALE | | 2. DATE AND HOUR PRONOUNCED DEAD (Found) May 24, 1966 9:50 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 25-31 D. STREET ADDRESS (If rural, give location) Unknown | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 2? |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |

| | | | | | | |
|---|--|---|--|--|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | (A) Cause of Death Undetermined. DUE TO | | | | | |
| | (B) DUE TO | | | | | |
| | (C) DUE TO | | | | | |
| | 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| | 20A. AUTOPSY? (Yes or No) Yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/24/66 | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 23B. DATE 9-7-66 | | 23C. NAME of CEMETERY or CREMATORY Medical Examiner Office | | |
| 23D. LOCATION (City, town, or county) (State) Baltimore Md. | | 24A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | | |
| 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR CITY MORGUE | | | | |

Found - Dumpster - 400 Bell Long Island ave.

66 09070

BALTIMORE CITY HEALTH DEPARTMENT

66 09070

BIRTH NO. 66-23843

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BABY

PRICE

2. DATE AND HOUR PRONOUNCED DEAD

August 25, 1966

11:50 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

421 E. Lafayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

August 24, 1966

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

1

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

--

14. MOTHER'S MAIDEN NAME

Malinda Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hyaline Membrane Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Immaturity.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/25/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATED

23B. DATE

9-7-66

23C. NAME OF CEMETERY or CREMATORY

Medical Examiner Office

23D. LOCATION (City, town, or county) (State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

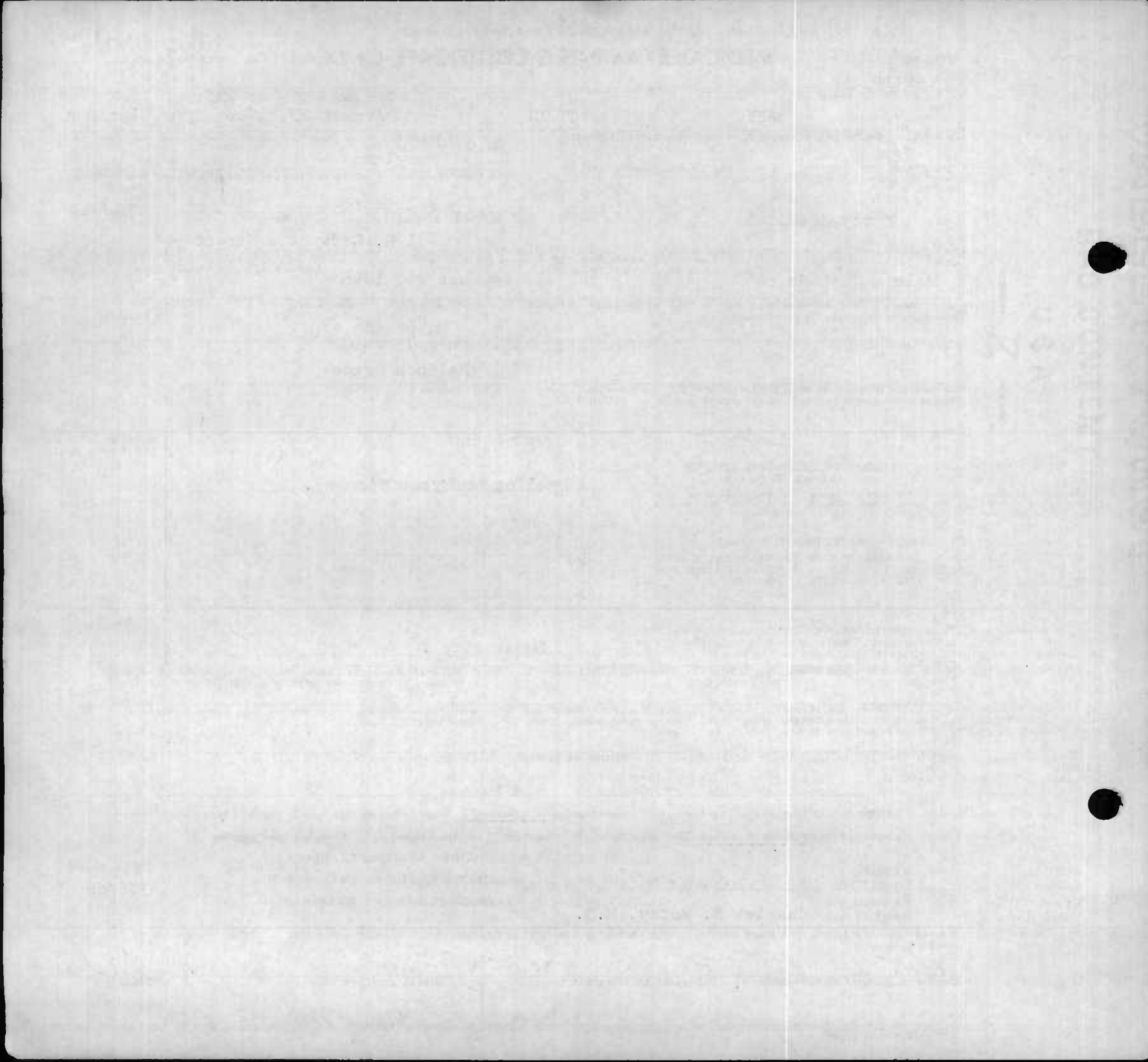
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 9 1966

CITY MORGUE



1
M-600

66 09071

BALTIMORE CITY HEALTH DEPARTMENT

66 09071

BIRTH NO. 66-20717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) BABY MOORE 2. DATE AND HOUR PRONOUNCED DEAD 7-5-66 1:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MERCY HOSPITAL - DOA 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 14-03 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2240 Druid Hill Avenue

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH 9. AGE (In years last birthday) Less than 1 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Post-natal asphyxia DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Delivery into toilet DUE TO (C) 14-03

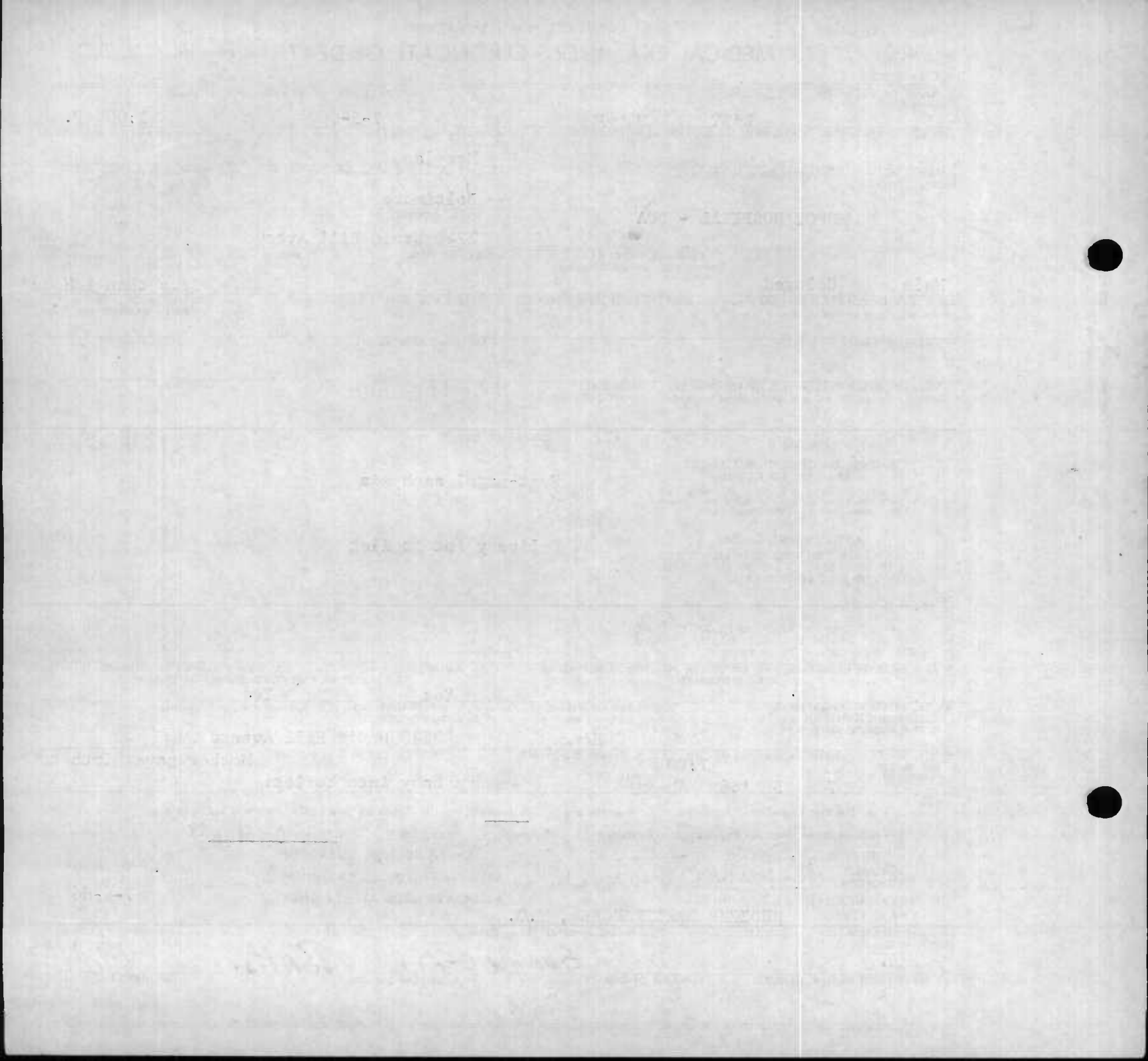
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2240 Druid Hill Avenue 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7:00 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Mother gave birth to baby into toilet

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 7-6-66 ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ ACTUAL SIGNATURE Rudiger Breitenecker M.D. EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify) Cremated 23B. DATE 9-7-66 23C. NAME OF CEMETERY or CREMATORY Medical Examiner Office 23D. LOCATION (City, town, or county) (State) Balt. Md.

24A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 24B. NAME OF REGISTRAR Robert E. Jarboe 24C. FUNERAL DIRECTOR CITY MORGUE ADDRESS



66 09072

BALTIMORE CITY HEALTH DEPARTMENT

66 09072

BIRTH NO. 66-12920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TONY WRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1966 11:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

John Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2062 E. Eager Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

2 wks.

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

14

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 756.2 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Peritonitis
DUE TO Acute Diverticulitis of Meckel's
Diverticulum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremated

23B. DATE

9-7-66

23C. NAME of CEMETERY or CREMATORY

Medical Examiner Office

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 9

1966

City of Baltimore

WATLEY POIRIE

MACDONALD

1944

1
D-525

66 09073

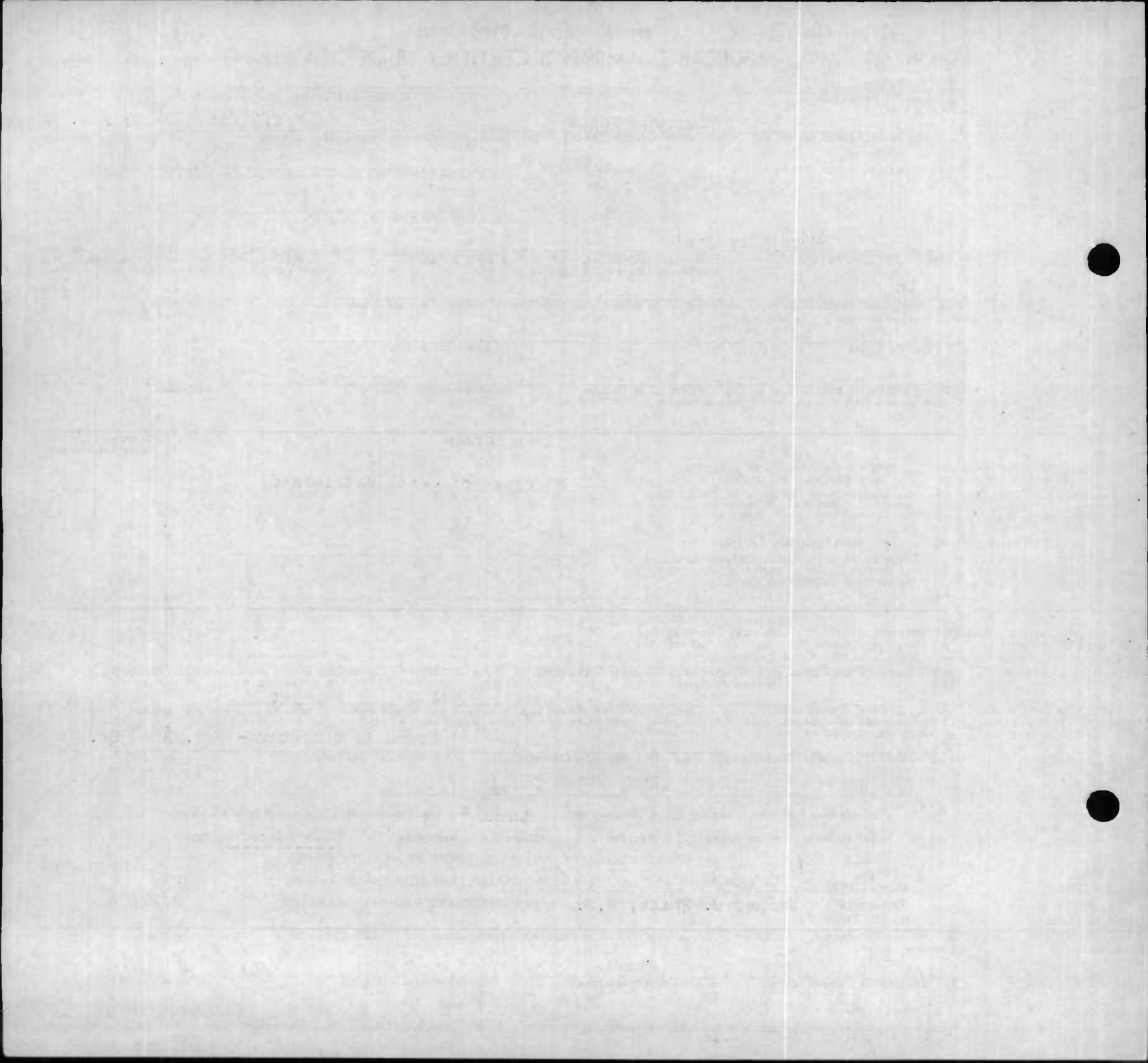
BALTIMORE CITY HEALTH DEPARTMENT

66 09073

BIRTH NO. 66-19936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

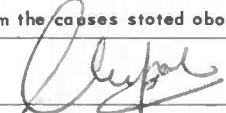
M.E. CASE NO. _____

| | | | | | |
|---|---------------------|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) Unknown Fetus | | | 2. DATE AND HOUR PRONOUNCED DEAD 8/21/66 2:55 p. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) UNKNOWN 00-00 D. STREET ADDRESS (If rural, give location) _____ | | |
| 5. SEX male | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____ | 8. DATE OF BIRTH _____ | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. 2? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) No cause of death determined ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) found in dumpster - 8 S. Bond St. | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/22/66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) CREMATED | | 23B. DATE 9-7-66 | 23C. NAME OF CEMETERY or CREMATORY Medical Examiner Office | | 23D. LOCATION (City, town, or county) (State) Balto. Md. |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS CITY MORGUE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|---------------------|--|--|--|---------------------------------------|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 66 09074 | | Registered No. 66 09074 | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BAER RAYMOND ARTHUR </div> <div> 2. DATE AND HOUR OF DEATH 8/30/66 11:20 PM </div> </div> | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY FROSTBURG ALLEGANY C. CITY OR TOWN (If outside city limits, write RURAL and give township) FROSTBURG 51-00 D. STREET ADDRESS (If rural, give location) Rt. 1# Box 157 - CARLOS | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/5/42 | 9. AGE (In years last birthday) 23 | If Under 1 Yr. Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | | 10B. KIND OF BUSINESS OR INDUSTRY A & P MARKET | | | 13. FATHER'S NAME RAYMOND S. BAER | | | 14. MOTHER'S MAIDEN NAME BEATRICE ALEXANDER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 216-40-3123 | | | 17. INFORMANT MRS. RAYMOND BAER, R.F.D.1, BOX 157, FROSTBURG, MD. | | | ADDRESS | | |
| 18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RUPTURED CEREBRAL ARTERY 4 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 9.00 20A. AUTOPSY? (Yes or No) 9.00 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from 8/28/66 19 66 to 8/30/66 19 66 , that (I) (we) last saw the deceased alive on 8/30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE  | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 8/30/66 | | |
| 23C. PHYSICIAN'S NAME (Type) ARNOLDO SCHUPAK | | | | | | 23D. ADDRESS UNIVERSITY HOSP. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE SEPT. 3, 1966 | | | 24C. NAME OF CEMETERY or CREMATORY VALE SUMMIT CEMETERY | | | 24D. LOCATION (City, town, or county) (State) VALE SUMMIT MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR HAFFER FUNERAL HOME 60 W MAIN ST., FROSTBURG, MD. | | | 25D. ADDRESS MARILOU SOWERS | | |

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

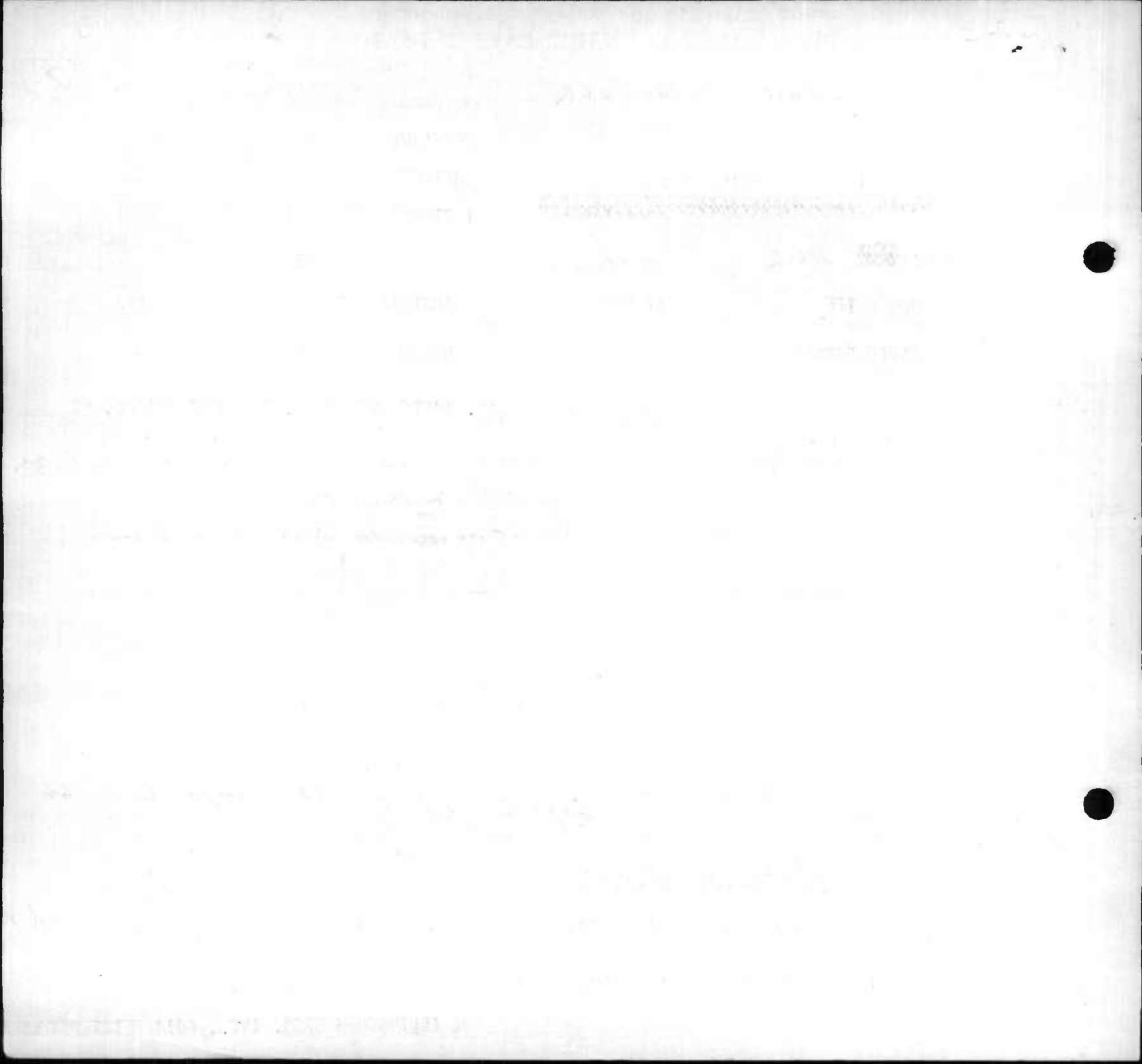
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FUNERAL DIRECTOR: IMPORTANT

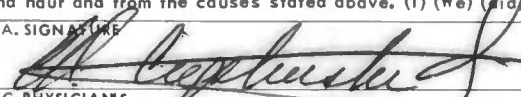
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09075</u> | |
|--|-------------------------|---|-------------------------------|--|---|
| BIRTH NO. <u>66 09075</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>JENNIE WEINSTOCK</u> | | 2. DATE AND HOUR OF DEATH <u>Sept 6/66</u> <u>2:50</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>BELVEDERE NURSING HOME</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| HOUSEHOLD ADDRESS | | D. STREET ADDRESS (If rural, give location) <u>1 STURGIS COURT #8</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>83</u> | 9. AGE (In years last birthday) <u>83</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>DAVID FARBER</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>MR. DAVID WEINSTOCK, 1 STURGIS PLACE, #8</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adenos carcinoma - proth. Lymphatic - metastatic</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO <u>Adenos carcinoma - proth. Lymphatic - metastatic</u> | | (B) DUE TO <u>Adenos carcinoma - proth. Lymphatic - metastatic</u> | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 1968</u> to <u>Sept 6 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 6 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Nathan E. Needle</u> M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/6/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NATHAN E. NEEDLE</u> M.D. | | 23D. ADDRESS <u>4215 - Park Heights Ave. Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/8/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>WORKMENS CIRCLE</u> | |
| 24D. LOCATION <u>BALTIMORE, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | |
| 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u> | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09076 | |
|--|---------|--|--------------------------|--|---|
| BIRTH NO. 66 09076 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Abraham Harris | | Sept 4th 1966 7.30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Md. Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-18 D. STREET ADDRESS (If rural, give location) 5418 Jonquil Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | White | Married | 7/4/04 | 62 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Accounting | | Sinai Hospital | | Russia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Louis Harris | | | Sophie ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-05-3850 | | Mrs. Ethel Harris 5418 Jonquil Avenue | |
| 18. 420.11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Acute Myocardial Infarction 10 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | ASCVD Unknown | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 25th 1966 to Sept 4th 1966, that (I) (we) last saw the deceased alive on Sept 4th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
|  | | | | Sept 4th 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| William Ciepiuski | | Sinai Hospital of Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9/5/1966 | | Farband Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR ADDRESS | | | |
| Baltimore, Maryland | | Sol Levinson & Bros. 6010 Reisterstown Road | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | Sol Levinson | | | |

to the
Hospital of Baltimore
24th July 1945

Baltimore
24th July 1945

Mrs. Mary
Married
Taylor 62
Russia

Acute Myocardial Infarction

ASGV

24th July 1945
24th July 1945
24th July 1945

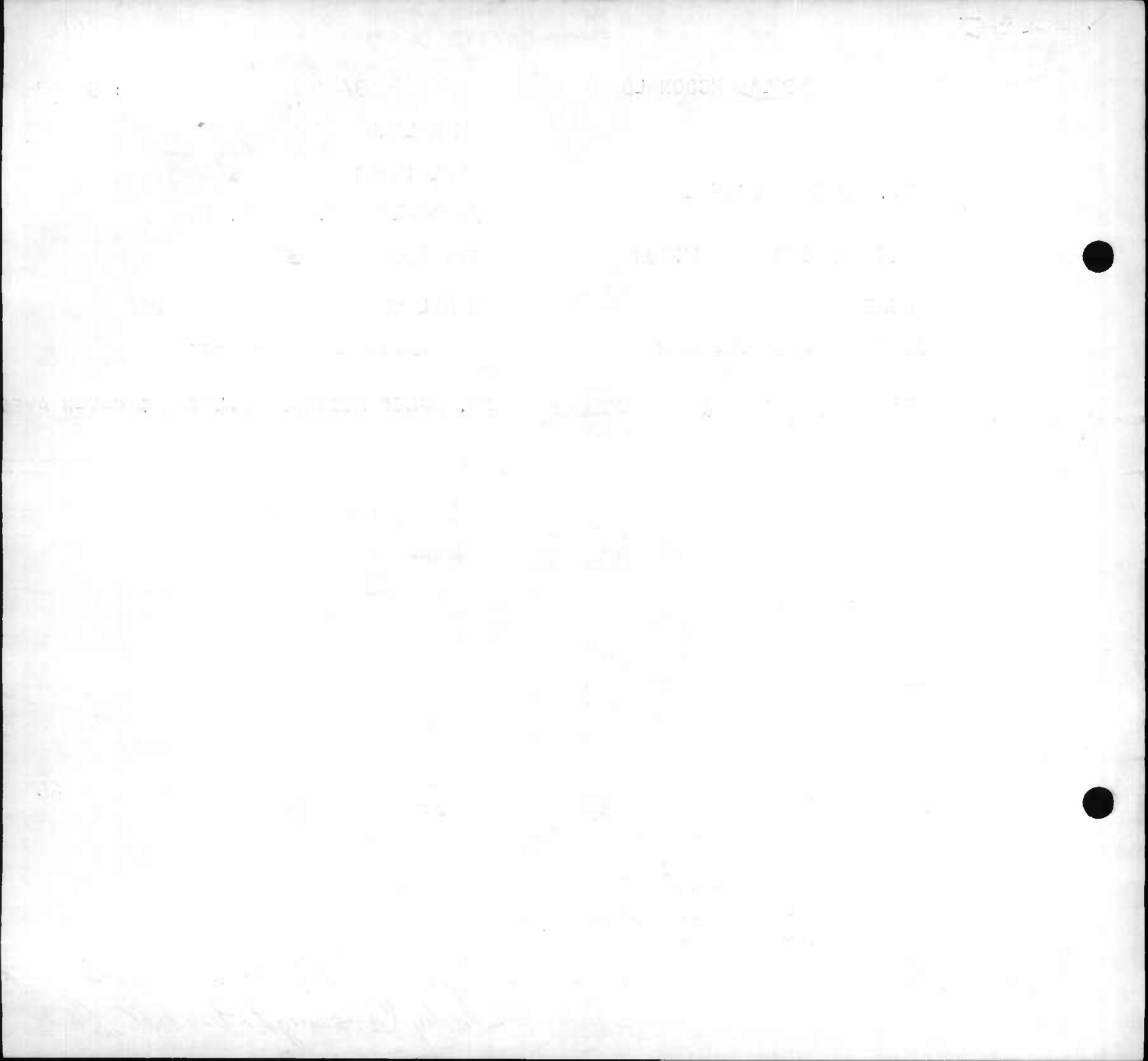
24th July 1945
24th July 1945
24th July 1945

~~W. H. H. H. H.~~
W. H. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

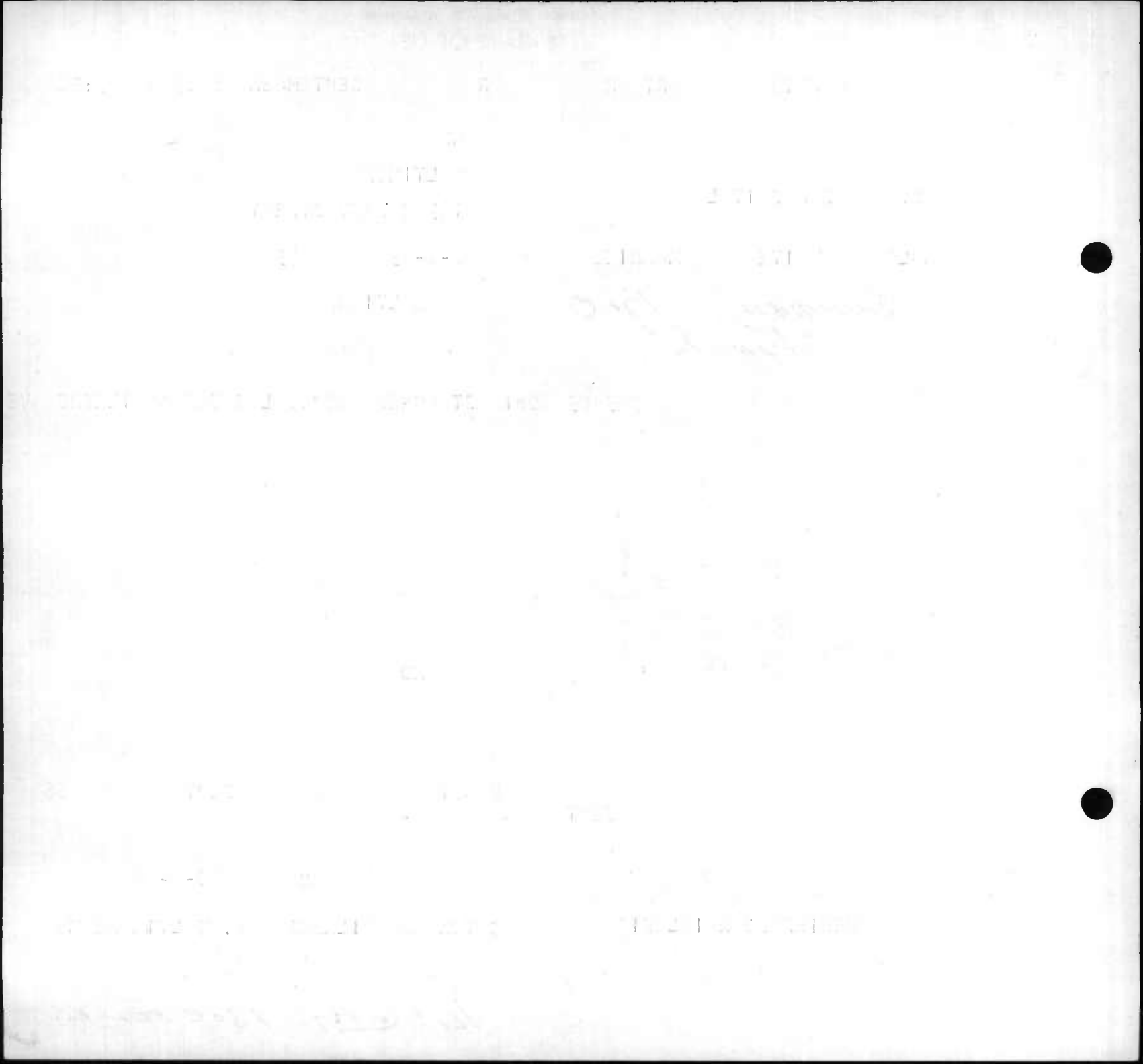
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|-------------------------------------|--|--|---|--|--|--|
| BIRTH NO. 66 09077 | | | | | REGISTERED NO. 66 09077 | | | | |
| M.E. CASE NO. | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | |
| 1. NAME OF DECEASED (Type or Print) BEULAH MCDONALD | | | | | 2. DATE AND HOUR OF DEATH 9/4/66 7:15 PM. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 500 YALE AVE. APT. 1A | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOW | 8. DATE OF BIRTH 11/24/80 | 9. AGE (In years last birthday) 86 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JOHN MC CAHAN | | | | | 14. MOTHER'S MAIDEN NAME LOUISE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON AVES | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C. V. A - PAROTITIS - | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 4/24/1966 to 9/4/1966 , that (X) (we) last saw the deceased alive on 9/4/1966 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dXXX) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE JUAN J. CABRERA | | | | | 23B. DATE SIGNED | | | | |
| 23C. PHYSICIAN'S NAME (Type) JUAN J. CABRERA | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-7-66 | | 24C. NAME OF CEMETERY OR CREMATORY Cathedral Cpn. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Farley Carrough | | 25D. ADDRESS Funeral Home | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09078 | |
|--|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09078 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MARTIN ARTHUR R | | 2. DATE AND HOUR OF DEATH SEPTEMBER 6 1966 7:20A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 143 E WEST STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-1-93 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAINMAN | | 10B. KIND OF BUSINESS OR INDUSTRY B.O. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME FRANK | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 705 05 6081 | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 151X I Carcinoma of stomach with metastases. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 26 1966 to SEPT 6 1966 , that (I) (we) last saw the deceased alive on SEPT 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wenfredo N. Iglesias | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) WENFREDO N IGLESIA | | 23D. ADDRESS M.D. CATON AND WILKENS AVE. BALTIMORE MD | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) B | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS 143 E WEST STREET | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM YANTZ

2. DATE AND HOUR PRONOUNCED DEAD

August 31, 1966 10:45 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1117 East Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1117 East Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

2-22-1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PAINTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Yantz

14. MOTHER'S MAIDEN NAME

Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)16. SOCIAL
SECURITY NO.

212-10-2014

17. INFORMANT

MARGARET SHORT

ADDRESS

305 MONTROSE

18.

416X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic Heart Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/31/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/8/66

23C. NAME OF CEMETERY or CREMATORY

MORELANDS

23D. LOCATION

BALTO

(City, town, or county)

MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 9 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

J.E. CONNELLY SONS

ADDRESS

300 MACE

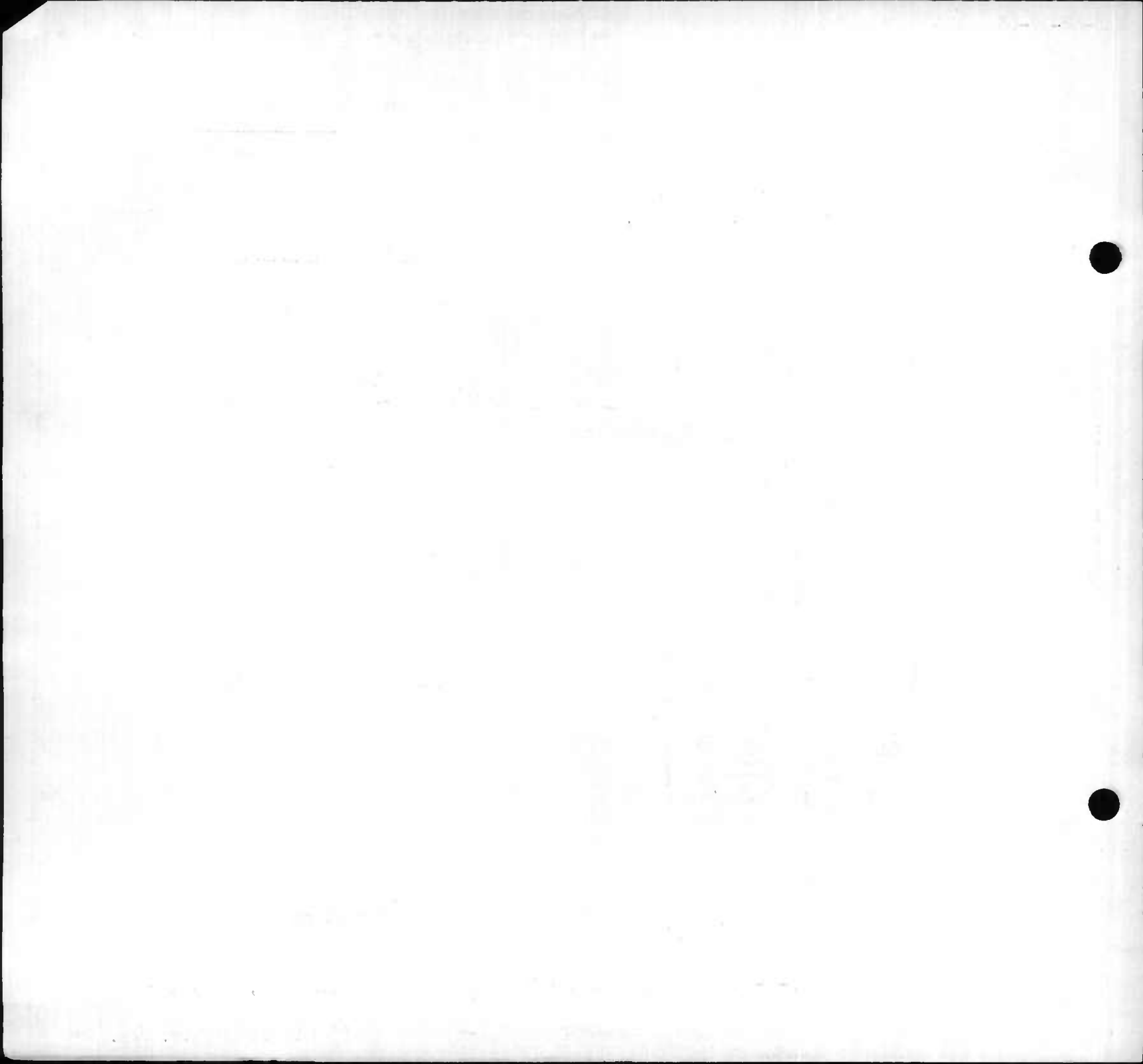
WALTER B. BROWN

WALTER B. BROWN

W

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-------------------------------|---|--|
| H 120 66 09080 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09080 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | George Hobbs | | 2. DATE AND HOUR OF DEATH 8:45 AM 9/6/66 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MARYLAND BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Maryland | | D. STREET ADDRESS (If rural, give location) 2101 N. Calvert St. | | 21218 | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced | 8. DATE OF BIRTH 8/18/1900 | 9. AGE (In years lost birthday) 65-66 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) not Tennessee | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME George | | 14. MOTHER'S MAIDEN NAME Florence Hobbs | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. not known | | 17. INFORMANT MRS MIGAN- Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH 216-70-0842 (A) esophageal pleural fistula DUE TO (B) ruptured esophageal diverticulum DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 15 19 66 to Sept. 6 19 66, and that (I) (we) lost saw the deceased alive on Sept 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Bruce M. Dow | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) Bruce M. Dow | | 23D. ADDRESS Baltimore City Hospitals, Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-8-66 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Ellsworth Anasch | | ADDRESS 4600 Liberty Hights. Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

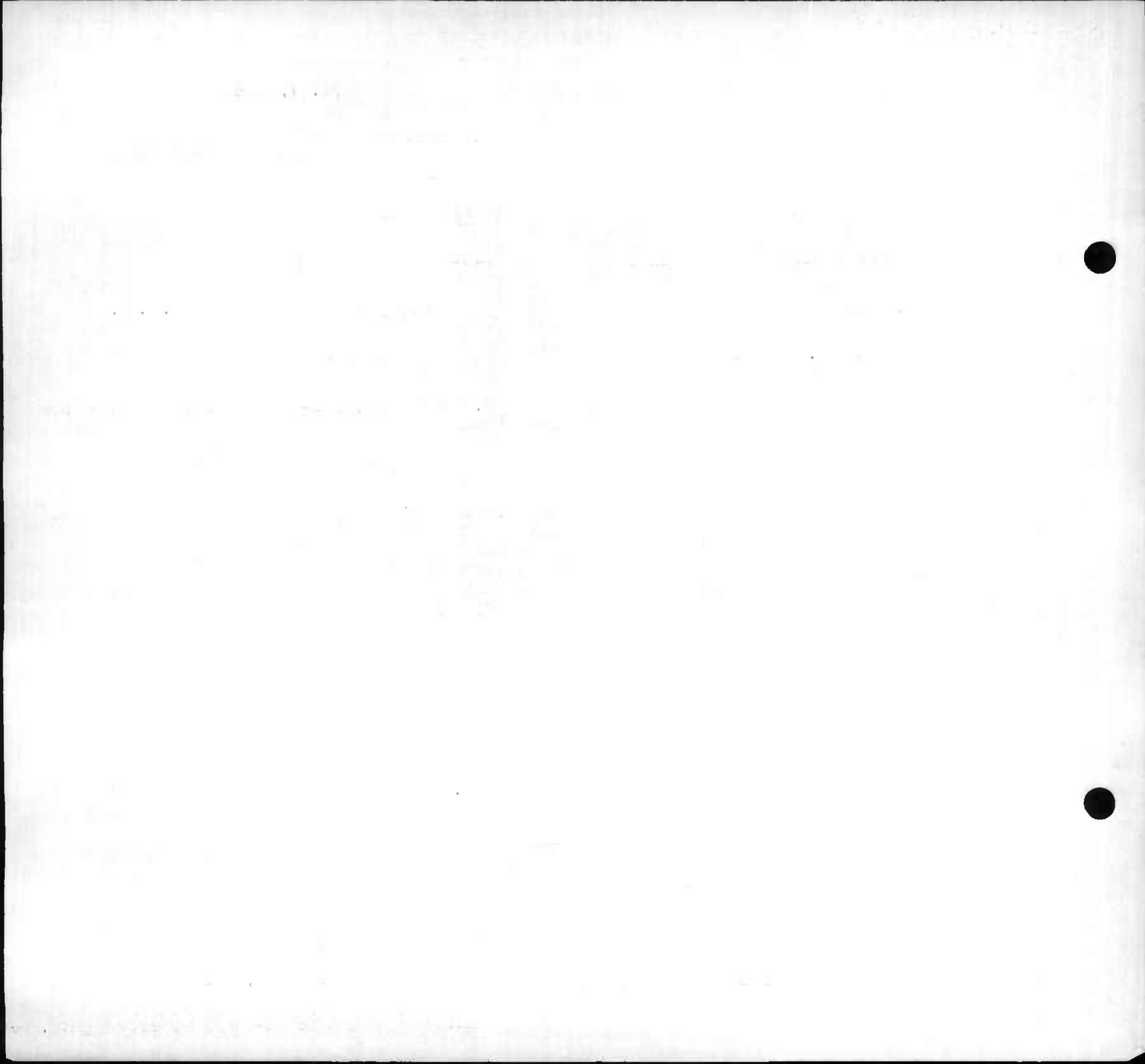
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|--|--|--|---|--|------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09081 | | | | |
| BIRTH NO. 66 09081 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM H WALTZ | | | | | 2. DATE AND HOUR OF DEATH SEPT. 6, 1966 10 20 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY BALTO | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 7032 HEATHFIELD ROAD | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 7-24-05 | 9. AGE (In years last birthday) 61 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKING | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | 13. FATHER'S NAME WILLIAM H. WALTZ SR | | | | |
| 14. MOTHER'S MAIDEN NAME JESSIE LETTS | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | |
| 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Helen J. Waltz | | | | |
| ADDRESS 7032 Heathfield Road | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) Cancer of the Lungs | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 31 19 66 to SEPT 6 19 66 , that (I) (we) last saw the deceased alive on SEPT. 6 , 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Adolfo G. de Perio | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED Sept. 6, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Adolfo G. DE PERIO | | | | | 23D. ADDRESS BON SECOURS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-10-66 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | | | 25B. NAME OF REGISTRAR Robert E. ... | | | | |
| | | | | | 25C. FUNERAL DIRECTOR XXXXXX | | | | |
| | | | | | ADDRESS 4600 Liberty Hights. Ave. | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|--|--|---|---|--|----------------------------------|--|
| BIRTH NO. 66 09082 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 09082 | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) Isabel Bowen Knowles | | | | | Sept. 7, 1966 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| 00 3921 Maine Avenue | | | | | Maryland | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 3921 Maine Avenue | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| Female | White | Single | | 1-5-1892 | 74 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| At Home | | | | | | Baltimore | | U.S.A. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Edwin W. Knowles | | | | | Annie Bowen | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | None | | J. Robert Taylor-3108 Brightwood Avenue | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO | | | Superior of Age | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO | | | Cerebral Vase Rupture & when | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) DUE TO | | | Generalized Arteriosclerosis | |
| II | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Some Diabetes | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 66 to Sept 7 19 66, that (I) (we) last saw the deceased alive on Sept 6 19 66 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | |
| R. Thomas G. Abbott | | | | | | | | 9-8-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Thomas G. Abbott | | | | | 4509 Liberty Heights Ave | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 9-9-66 | | Woodlawn Cemetery | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| SEP 9 1966 | | Robert E. Taylor | | Ellsworth Armacost | | | 4600 Liberty Hgts. Ave | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 66 09083 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09083 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ALVERTA E. BOSTON | | 2. DATE AND HOUR OF DEATH Sept. 8, 1966 2:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. AGE (In years last birthday) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Carver Memorial Home | | A. STATE Baltimore B. COUNTY 13-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| D. STREET ADDRESS (If rural, give location) | | E. CITY OR TOWN | | F. STREET ADDRESS | |
| 15. SEX F | | 16. RACE C | | 17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| 18. DATE OF BIRTH July 9, 1915 | | 19. AGE (In years last birthday) 51 | | 20. If Under 1 Yr. Months: Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Teacher (Ret.) | | Public school | | Howard Co. Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John H. Boston | | Harriett A. Hall | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Mrs. Alice Vinder | |
| | | | | 2302 W. E. Culbert St. | |
| 18. 350X1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Bronchopneumonia | | 1 wk. | |
| ANTECEDENT CAUSES | | (B) Parkinson's Disease | | Unknown | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertension | | Unknown | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Coronary Arteriosclerosis | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 4, 1966 to Sept. 8, 1966 , that (I) (we) last saw the deceased alive on 9/6/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E.E. Holt | | | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) E.E. Holt | | | | 23D. ADDRESS 3715 Liberty Hts. Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/11/66 | | Trinity Zion | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 9 1966 | | Robert E. Tolson | | Funeral Home | |
| | | | | 1631 1/2 N. Highland Ave. | |

66 09084

BALTIMORE CITY HEALTH DEPARTMENT

66 09084

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Shelvy
Shelvy Crabtree

2. DATE AND HOUR PRONOUNCED DEAD

9/3/66 12:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5219 Brookwood Ave Rd

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-29-42

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richland, Va.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew Asbury

14. MOTHER'S MAIDEN NAME

Novella Pennington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.17. INFORMANT
Husband

ADDRESS

5219 Brookwood Rd.,

Paul J. Crabtree - Brooklyn, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Potee St. near Waterview Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 3 66 12:05a.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

driver of auto which struck curb and
overturned

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6 Sept. 66

23C. NAME of CEMETERY or CREMATORY

Rhudy Cemetery

23D. LOCATION

(City, town, or county)

(State)

Tazewell, Va.

24A. DATE REC'D BY HEALTH DEPT.

SEP 9 1966

24B. NAME OF REGISTRAR

Robert E. Feltman

24C. FUNERAL DIRECTOR

ADDRESS

Kirkley Funeral Home, 421 Crain Hwy., S.E.
Glen Burnie, Maryland 21061

WALTER
AND COUNTRY
J. A. A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

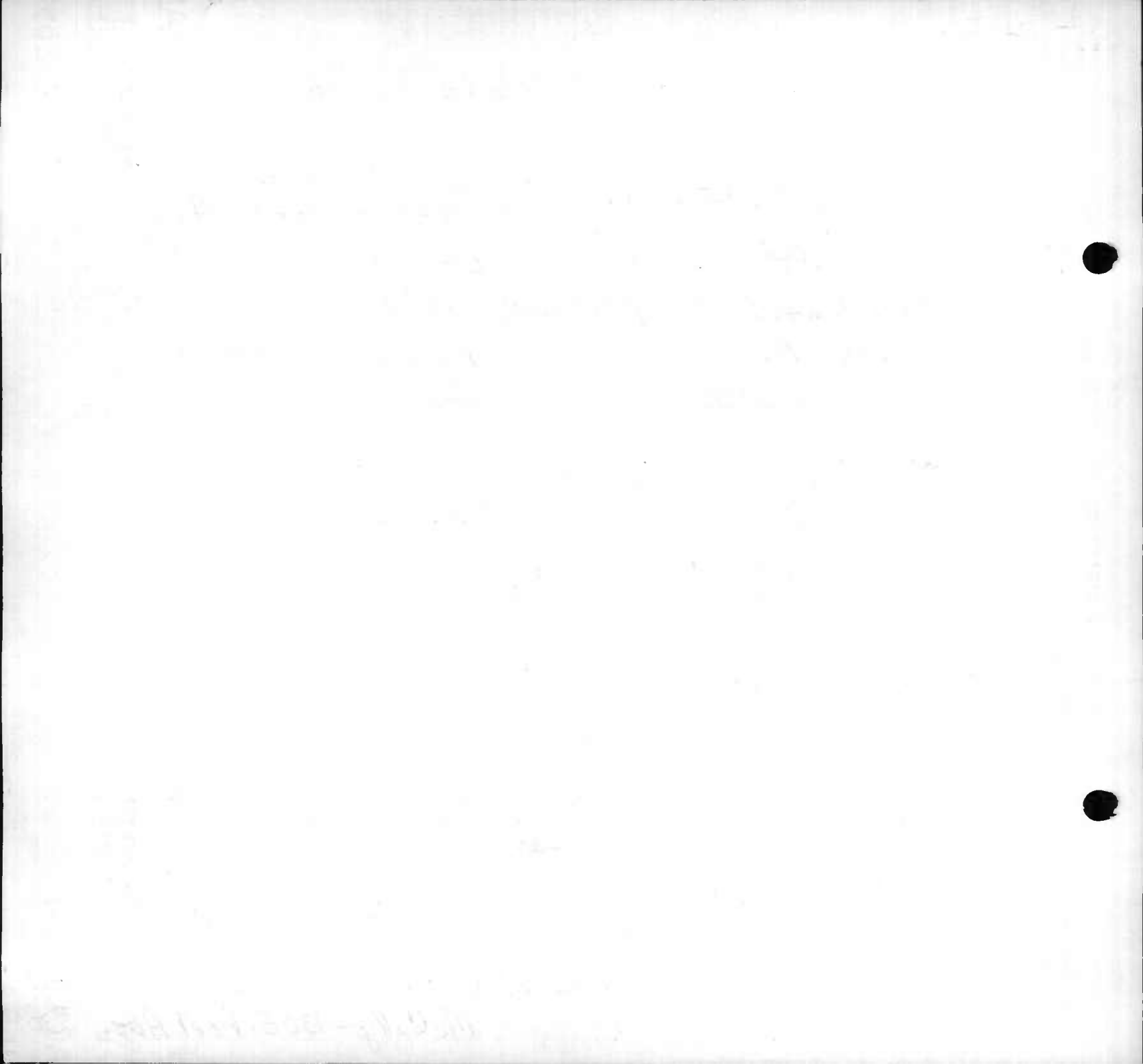
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09085 | |
|--|------------------|--|----------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09085 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CAMPBELL, Guy | | 2. DATE AND HOUR OF DEATH September 6 th 1966 4 ⁴⁵ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, Md. | | A. STATE 8. COUNTY 1032 Sharp St. Baltimore, Md. #30 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE city. | | | |
| | | D. STREET ADDRESS (If rural, give location) 1032 Sharp St. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH MAR 13, 1901 | 9. AGE (In years last birthday) 65 years | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) S. C. | |
| 13. FATHER'S NAME Butler Campbell | | 14. MOTHER'S MAIDEN NAME Georganna | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (Widow) BERTHA CAMPBELL ADDRESS S/A | |
| 18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Septic shock, Septicemia DUE TO (B) Massive Left Lung DUE TO (C) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Left. Bronchial - Pneumonia + Anuria | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-24 1966 to 9-6 1966, that (I) (we) last saw the deceased alive on 9-6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE L. Shama | | | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) L. Shama | | | | 23D. ADDRESS UNIVERSITY HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY or CREMATORY MOUNT AUBURN | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTO Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ISAIAH L. BROWN + Son | |
| | | | | ADDRESS 123 W. MONTGOMERY ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--------------------------------------|--|---|
| BIRTH NO. 66 09086 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09086 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Thomas Carroll Wade | | 2. DATE AND HOUR OF DEATH 9-6-66 7:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION S.B.G.H. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 760 E. Fort Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 6-15-1917 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrolman | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City Police | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Chas. F. | | 14. MOTHER'S MAIDEN NAME ANNIE E. LAMARE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) DUE TO Crownary thrombosis (B) DUE TO Antepartum C.V. disease (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1 19 64 to Sept 19 66 , that (I) (we) last saw the deceased alive on 9/1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE EP Hoff | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) E.P. Hoff Jr | | 23D. ADDRESS 3100 St Paul St - 18 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-10-66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR DR. S. E. Johnson | | 25C. FUNERAL DIRECTOR McCally ADDRESS 130 E. Fort Ave. #30 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

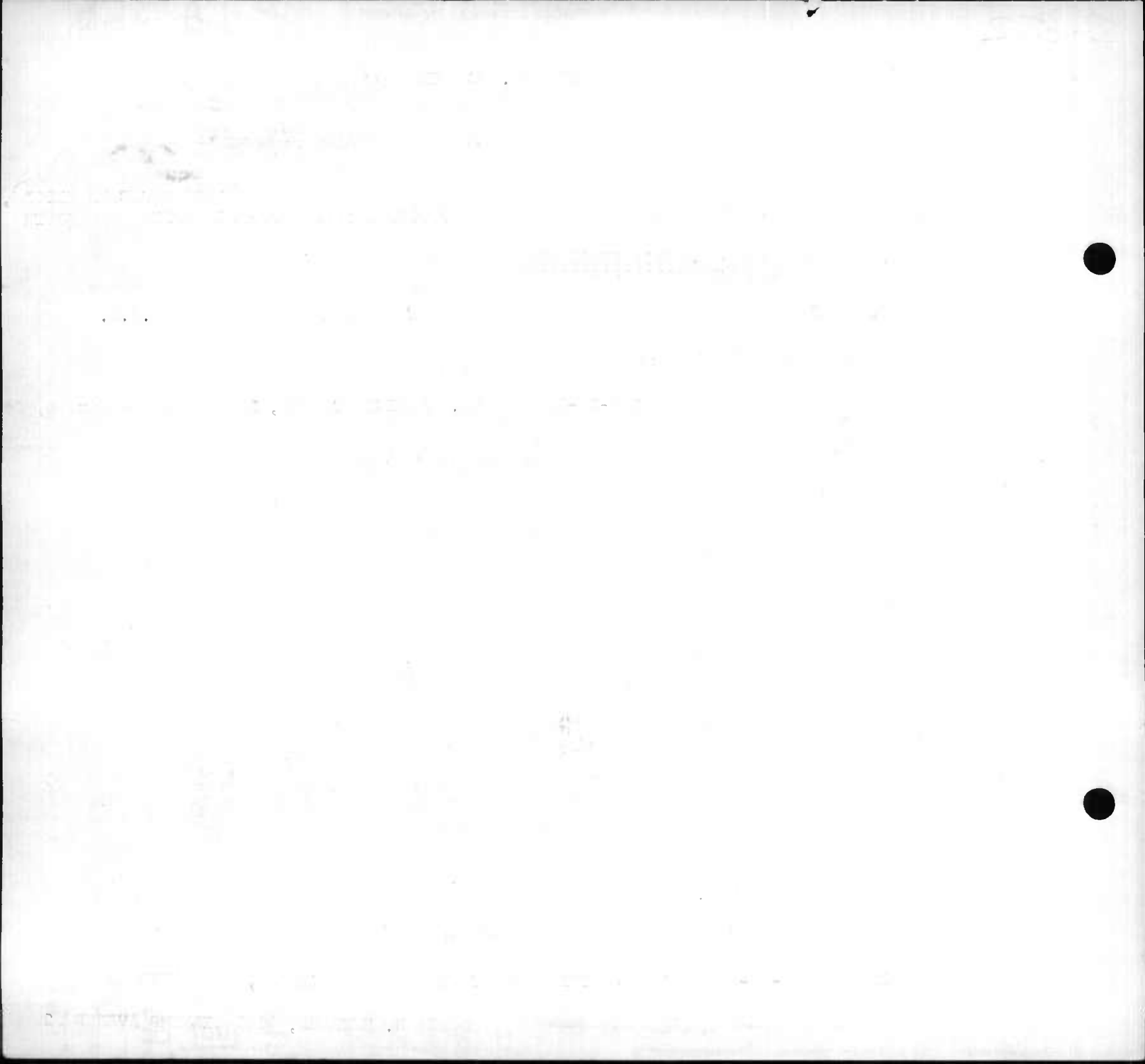
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09087 | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 66 09087 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROY K. SCHWARTZ SR. | | 2. DATE AND HOUR OF DEATH 9-5-66 7:00PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FREDERICK | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODSBORO 60-11 | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 | | D. STREET ADDRESS (If rural, give location) RT 1 RENNER ROAD | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-20-95 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mech Broker | | 10B. KIND OF BUSINESS OR INDUSTRY Self Emp. | | 11. BIRTHPLACE (State or foreign country) Carroll Co. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM | | 14. MOTHER'S MAIDEN NAME ANNIE GETZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/8/17 - 12/2/18 | | 16. SOCIAL SECURITY NO. 218-10-4522 | | 17. INFORMANT Erna Mrs. Erna D. Schwartz-Royshirt | |
| 18. 451X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Sudden cardiac arrest - probable myocardial infarction - 2-3 min (B) Anterioschotic cardiac disease (C) Dissecting thoracic aortic aneurysm | | INTERVAL BETWEEN ONSET AND DEATH 8-13-66 | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral pneumonia & renal failure | | | | | |
| 19A. DATE OF OPERATION 8-16-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting thoracic aortic aneurysm | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 8-13-66 1966 to Sept 5 1966, and that (I) (we) last saw the deceased alive on 8-9-66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Brian D. Lowry M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-5-66 | |
| 23C. PHYSICIAN'S NAME (Type) BRIAN D. LOWRY M.D. | | 23D. ADDRESS 601 N. BROADWAY BALTIMORE, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | |
| 25C. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

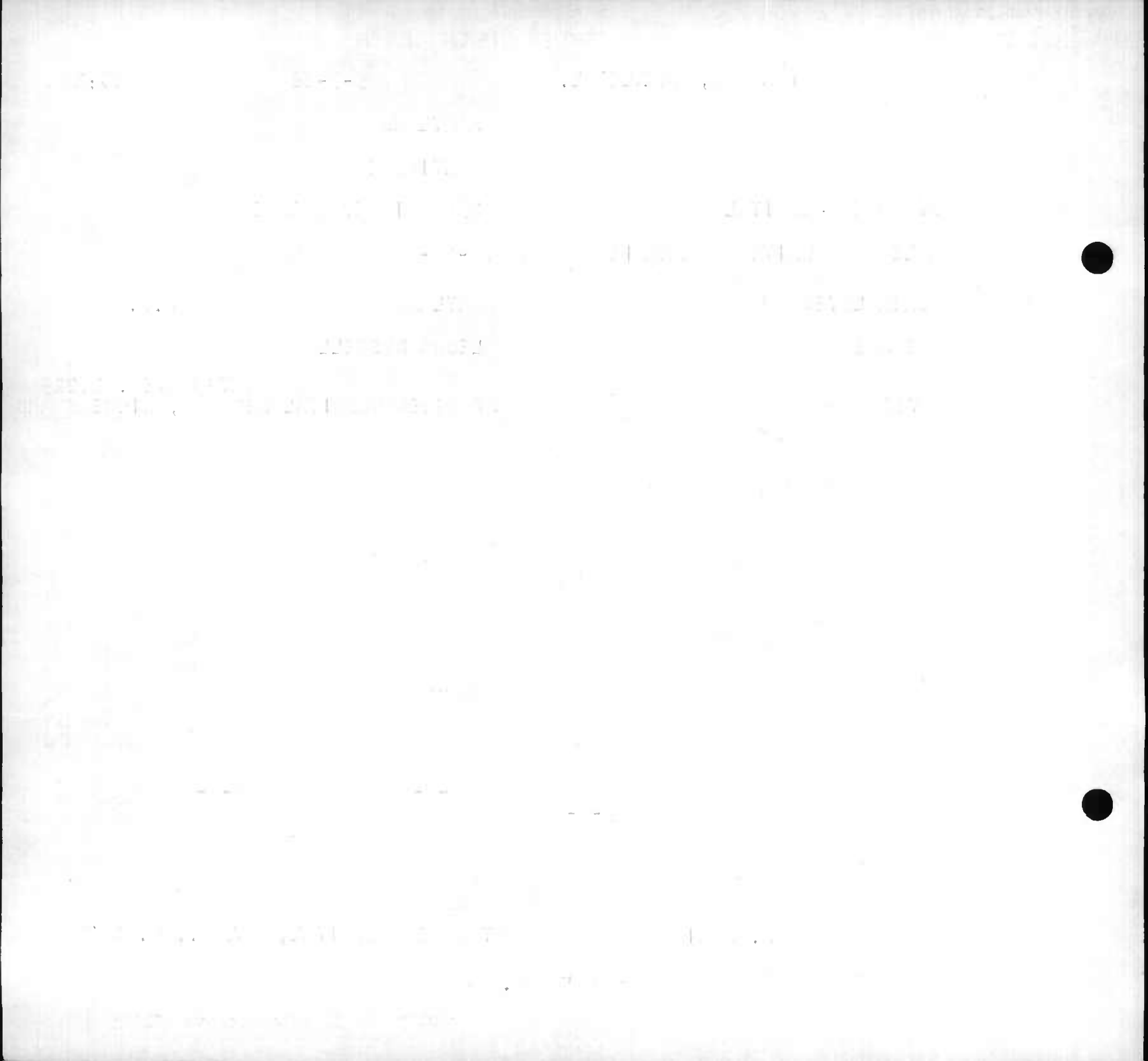
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 09088</u> | |
|--|----------------------|---|-------------------------------------|--|--|---|--|
| BIRTH NO. <u>66 09088</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>STANCIL, John</u> | | JOHN H. STANCIL | | 2. DATE AND HOUR OF DEATH <u>9/6/66 11:14/p.m.</u> | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 Johns Hopkins Hospital</u> | | | | A. STATE <u>md.</u> | | | |
| | | | | B. COUNTY <u>Anne Arundel</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>2800 EDGECOMB CIRCLE, SOUTH</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>10-19-38</u> | 9. AGE (In years last birthday) <u>27</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u> |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William J. STANCIL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie L. Taylor</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-36-7344</u> | | 17. INFORMANT <u>MR. RALEIGH STANCIL, 2800 Edgcomb Circle, So</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Subacute Glomerulonephritis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0 none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>no</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>no</u> | | 21F. HOW DID INJURY OCCUR? <u>no</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/1/66</u> to <u>9/6/66</u> and that (I) (we) last saw the deceased alive on <u>9/6/66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>C. H. Brown, III</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/6/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>C. H. Brown III</u> | | | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-10-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>GOOD SHEPARD CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

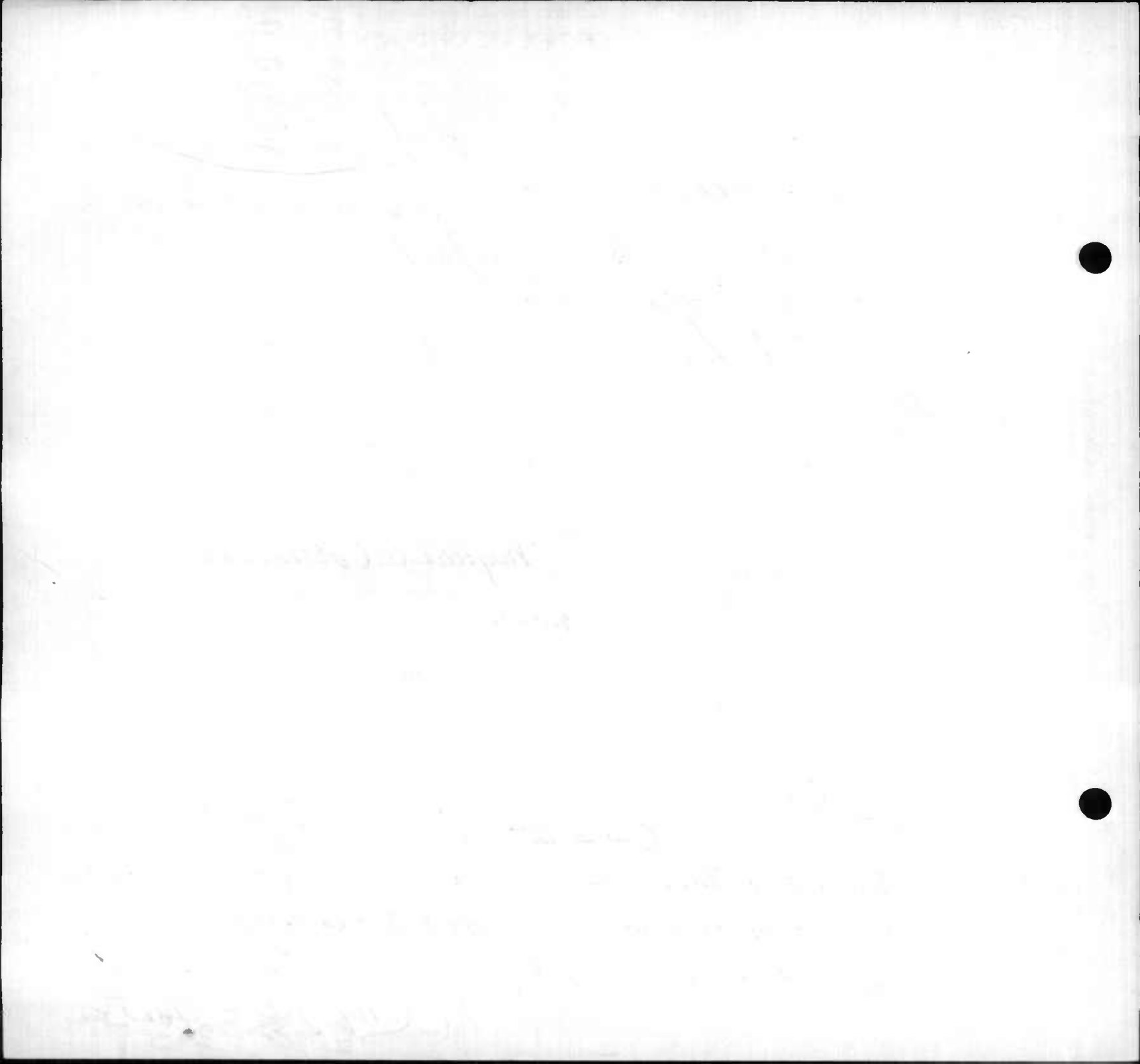
| | | | | | | | |
|---|---------------|--|---------------------------|--|-----------------------------|--|------------------------------|
| BIRTH NO. 66 09089 | | BALTIMORE CITY HEALTH DEPARTMENT | | Certificate of Death | | Registered No. 66 09089 | |
| M.E. CASE NO. H | | 1. NAME OF DECEASED (Type or Print) TOMPSON, CHARLES L. | | 2. DATE AND HOUR OF DEATH 9-7-66 11:20A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | A. STATE MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2327 SIDNEY AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-27-36 | 9. AGE (In years last birthday) 29 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME GEORGE | | | | 14. MOTHER'S MAIDEN NAME LEONA RUSSELL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS CATON AVES. 21229 ST AGNES HOSPITAL RECORDS, WILKENS AND | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO Chronic Coronary atherosclerosis (B) DUE TO Chronic Hypertension (C) DUE TO Hypertensive Encephalopathy | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-5-1966 to 9-7-1966, that (I) (we) last saw the deceased alive on 9-7-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. MARIN | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) R. MARIN | | | | 23D. ADDRESS M.D. ST AGNES HOSPITAL, BALTO., MD. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY or CREMATORY Balto Nat'l Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS McCully FH 237 Patapsco Ave 21225 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 09090 | |
|---|------------------|--|----------------------------------|--|--|--|-----------------------|
| BIRTH NO. 66 09090 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>John E. Quinn</i> | | 2. DATE AND HOUR OF DEATH <i>9-7-66 7 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | CITY OR TOWN (If outside city limits, write RURAL and give township) | | A. STATE <i>Ind.</i> | | P. COUNTY | |
| <i>102 WALLER AVE</i> | | <i>BALTO.</i> | | <i>Ind.</i> | | | |
| D. STREET ADDRESS (If rural, give location) | | <i>102 WALLER AVE</i> | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>S.</i> | 8. DATE OF BIRTH <i>10/30/13</i> | 9. AGE (In years, last birthday) <i>52</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>BALTO City</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ind.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Ed. L.</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Cora May Beatz</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Family - Jane</i> | | | |
| 18. <i>420.1 I</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | <i>Coronary Thrombosis</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <i>Myocardial Ischemia</i> | | | |
| (C) DUE TO | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>none</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) <i>this hospital</i> attended the deceased from <i>7/4</i> 19 <i>66</i> to <i>9/7</i> 19 <i>66</i> , that (1) <i>we</i> last saw the deceased alive on <i>9/7</i> 19 <i>66</i> and that is (my) <i>last</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>we</i> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Vincent M. Messina</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/7/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Vincent M. Messina</i> | | | | 23D. ADDRESS <i>1403 S. Charles St BALTO 21230 MD</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE <i>9.10.66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>CATH.</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talbot</i> | | 25C. FUNERAL DIRECTOR <i>McElroy</i> | | ADDRESS <i>130 E Foul A</i> | |



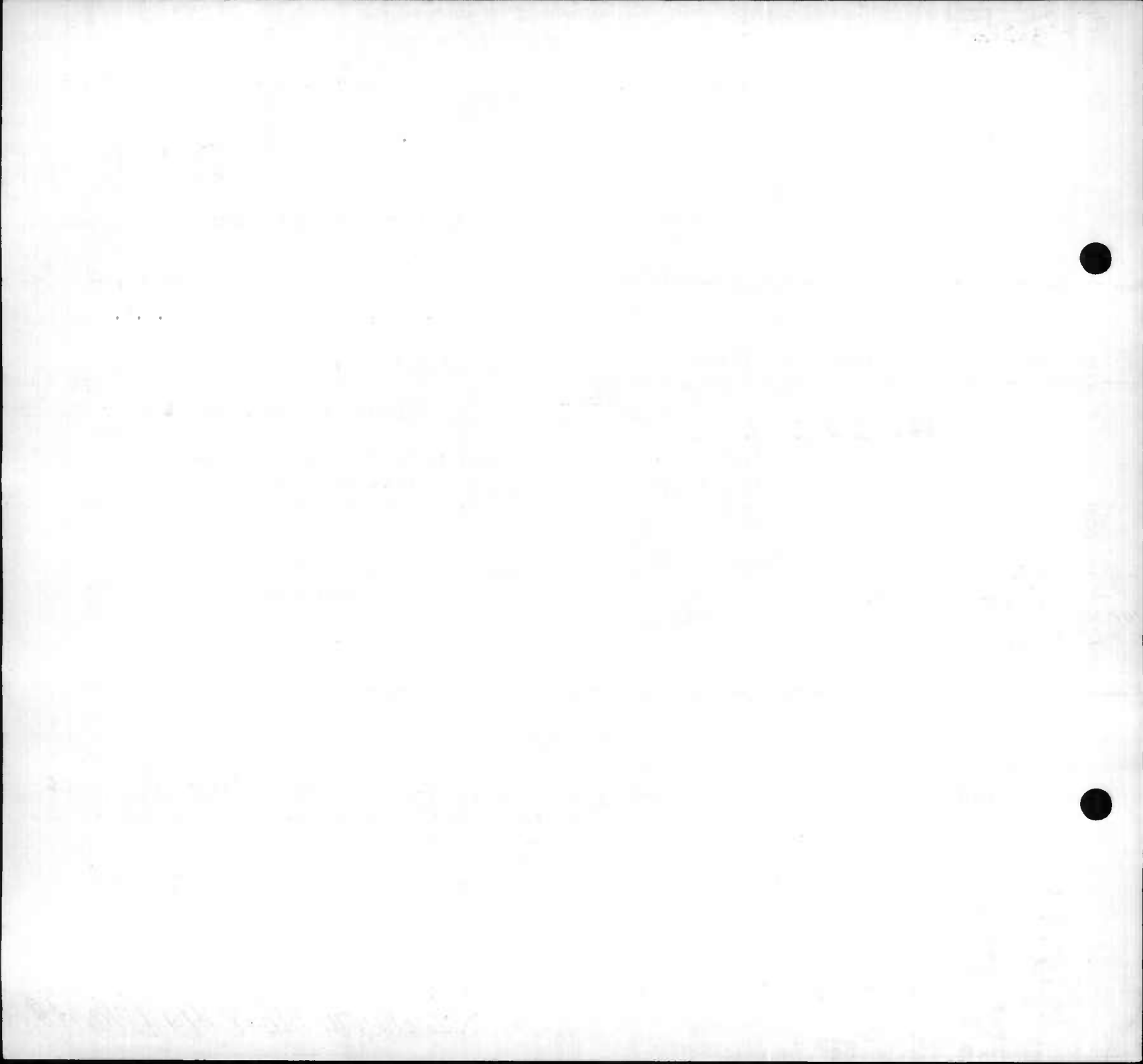
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09091 | |
|--|-------------------------|--|------------------------------------|---|--|
| BIRTH NO. 66 09091 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Sarah Rebecca Fleet</i> | | 2. DATE AND HOUR OF DEATH <i>Sept 6, 1966 12:45 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1902 Homewood Ave.</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i> | 8. DATE OF BIRTH <i>10/6/00</i> | 9. AGE (In years last birthday) <i>60</i> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Louis Fleet</i> | | 14. MOTHER'S MAIDEN NAME <i>Charlotte Fleet</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>215-32-2914</i> | | 17. INFORMANT <i>Miss Pearl B. Brown</i> ADDRESS <i>1902 Homewood Ave.</i> | |
| 18. <i>331 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Intracerebral Hemorrhage</i> DUE TO (B) _____ DUE TO (C) <i>Ba</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 4 1966</i> to <i>Sept 6 1966</i> , that (I) last last saw the deceased alive on <i>Sept 6 1966</i> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nat E. Watson, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/6/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>NAT E. WATSON</i> | | 23D. ADDRESS M.D. <i>THE UNION MEMORIAL HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-10-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Arboretum Park Bacter City</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i> | |
| 25C. FUNERAL DIRECTOR <i>Thomas A. Hemmley</i> | | 25D. ADDRESS <i>578 W. Bidelle</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09092 | |
|---|-------------------------|---|--------------------------------------|---|--|
| F-436 | | 66 09092 | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Emma Felter | | 2. DATE AND HOUR OF DEATH 9/6/66 11:03 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Gould Convalesarium 6116 Bealr Road | | A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4312 Forrest View Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-14-1883 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Henry Engelhardt | | 14. MOTHER'S MAIDEN NAME Emma | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-05-9776 | | 17. INFORMANT Mrs Alberta Schlepner ADDRESS 36 4401 Ebenezer Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular and cerebral vascular disease with left hemiplegia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21. MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 10 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from December 3 19 62 to Sept 6 19 66 , that (I) (we) last saw the deceased alive on Sept 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-9-1966 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Tolson | | 25C. FUNERAL DIRECTOR Supakungun's Home ADDRESS 87401 Belair Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|---|--|--|
| BIRTH NO. 66 09093 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09093 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) BRUST, WILLIAM CARL | | | 2. DATE AND HOUR OF DEATH 9/3/66 8:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. | | | A. STATE MARYLAND B. COUNTY Balto | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| 44 | | | D. STREET ADDRESS (If rural, give location) 240 Rodgers Forge Rd. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 06-01-95 | 9. AGE (In years last birthday) 71 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Fire Dept. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME FREDERICK BRUST | | | |
| 14. MOTHER'S MAIDEN NAME MARTHA SCALES | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW-1 | | | |
| 16. SOCIAL SECURITY NO. 219-30-9036A | | 17. INFORMANT ADDRESS Mrs. Mildred Brust (Widow) | | | |
| 18. 527.1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Pneumonia DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION last. | | (B) Emphysema DUE TO | | | |
| | | (C) Pulmonary emphysema DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemorrhagic gastritis | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/3/1966 to 9/3/1966 . that (I) (we) last saw the deceased alive on 9/3/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Zoltan Zarday | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/3/66 | |
| 23C. PHYSICIAN'S NAME (Type) ZOLTAN ZARDAY | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/7/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l. Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR P. G. E. Tolson | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Road, 21212 | | | |

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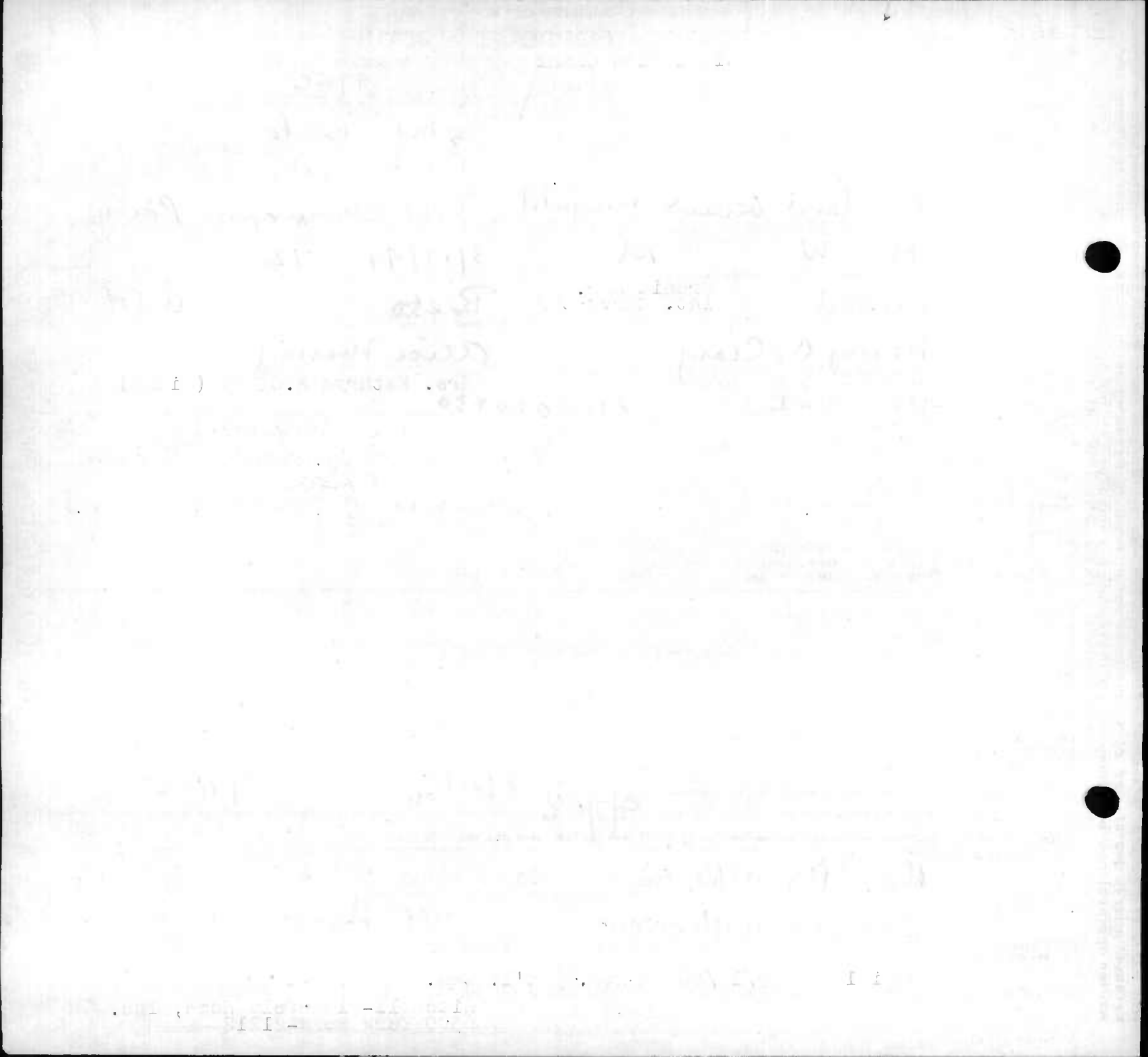
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FUNERAL DIRECTOR: IMPORTANT

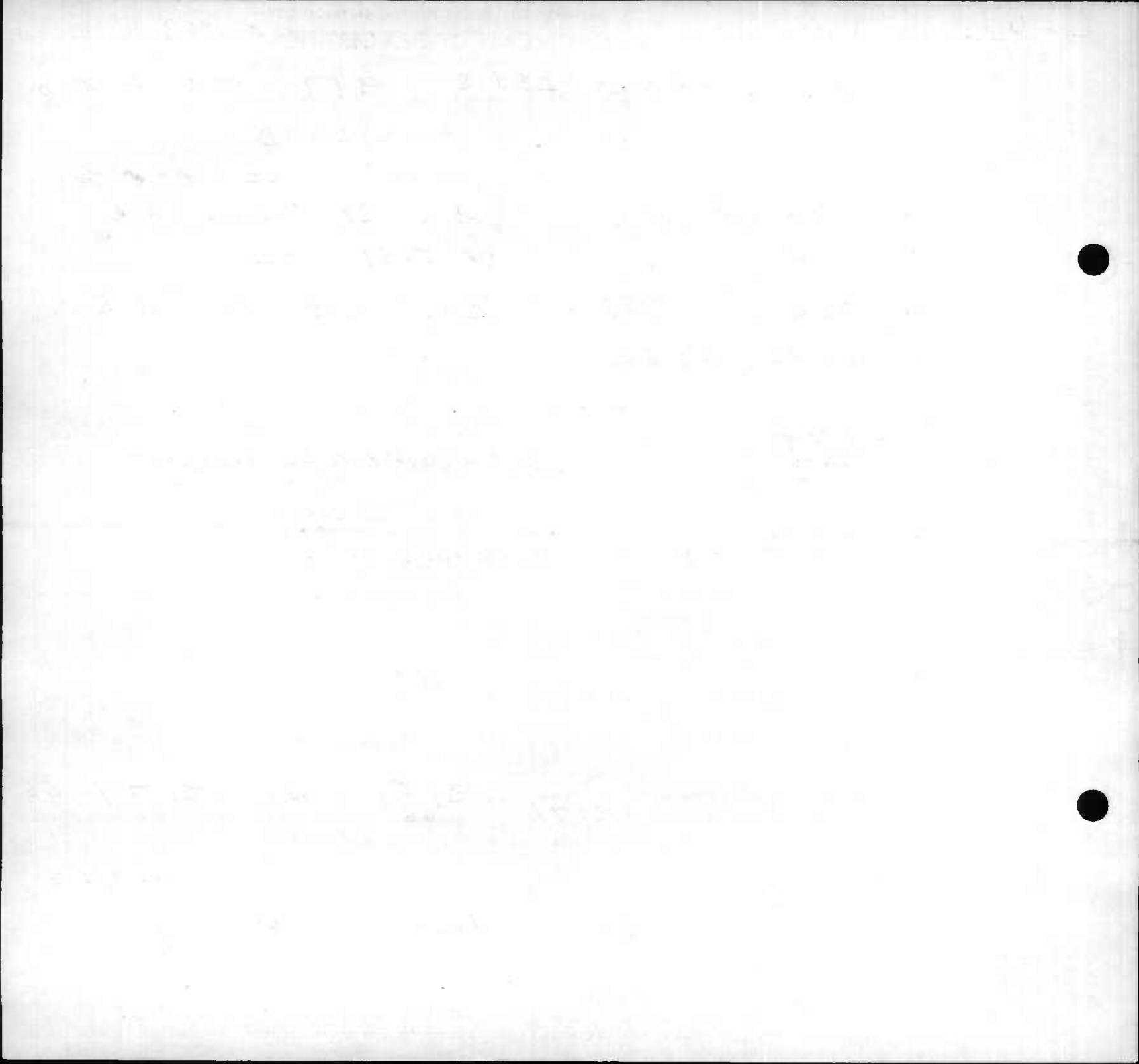
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09094 | |
|---|--|--|--|---|--|
| BIRTH NO. 66 09094 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 66 09094 | | | | 1. NAME OF DECEASED (Type or Print) FRANCIS IRVING CLARY | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND Frank I Clary | | | | 2. DATE AND HOUR OF DEATH 9766 13:35 P M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) #8 Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B Md B. COUNTY Balto. | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto md. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | | D. STREET ADDRESS (If rural, give location) 5701 Chingwapien Pkwy | |
| 10B. KIND OF BUSINESS OR INDUSTRY Credit Mgr. Int. Harvester | | | | 8. DATE OF BIRTH 3/17/94 9. AGE (In years last birthday) 72 | |
| 11. BIRTHPLACE (State or foreign country) Balto | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry C. Clary | | | | 14. MOTHER'S MAIDEN NAME Alice Manning | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI | | | | 16. SOCIAL SECURITY NO. 212-010430 | |
| 17. INFORMANT Mrs. Kathryn M. Clary (Widow) | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 153.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MASSIVE HEPATIC CARCINOMA | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA of TRANSVERSE COLON | | | | (A) DUE TO (B) DUE TO (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/21/66 19 to 9/7/66 19, that (I) (we) last saw the deceased alive on 9/7/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel C. Wilkerson M.D. | | | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson | | | | 23D. ADDRESS 421 Regester Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. NAME OF REGISTRAR John E. Taylor | | 24F. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Road-21212 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

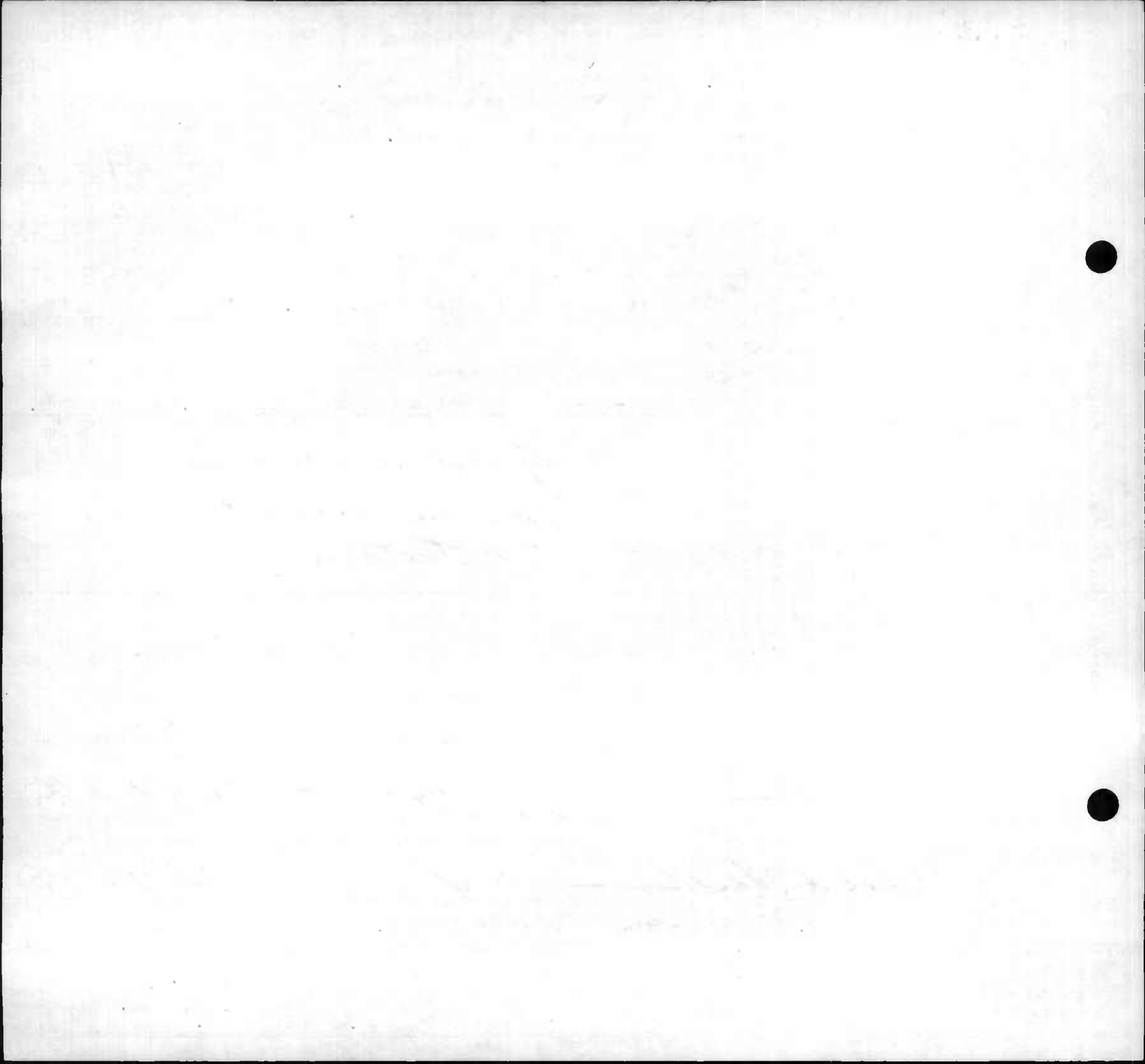
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|--|---------------|--|------------------------------|---|---|
| BIRTH NO. 66 09095 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09095 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ADER, HENRY LOUIS | | 2. DATE AND HOUR OF DEATH 9/7 1966 4 30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) 4111 St. Thomas Ave. | | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W. | 8. DATE OF BIRTH 08-15-94 | 9. AGE (In years lost birthday) 72 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER | | 10B. KIND OF BUSINESS OR INDUSTRY Monumental Press | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |
| 13. FATHER'S NAME CHARLES ADER | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1 | | 16. SOCIAL SECURITY NO. 215-01-3360 | | 17. INFORMANT Mrs. Mildred Kannler, dght. above | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CEREBROVASCULAR ACCIDENT DUE TO (B) HYPERTENSION DUE TO (C) CIRRHOSIS OF LIVER | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/5/1966 to 9/7/1966, that (I) (we) last saw the deceased alive on 9/7/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Zoltan Zarday | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) ZOLTAN ZARDAY | | 23D. ADDRESS Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|--------------------------|--|--------------------------------|
| 66 09096 | | CERTIFICATE OF DEATH | | 66 09096 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | PEARL E. ROTHHAUPT | | Sept. 6, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Church Home Hospital | | Md. 21231 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 108 N. Washington Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| female | white | widowed | 3/5/1898 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | at home | | Baltimore, Md. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Laster | | | unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 219-22-0635 | | Thelma Tabor, dght, 702 N. Luzerne Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. 170X I | | Generalized edema | | | |
| 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Carcinoma of breast | | 2 yrs | |
| | | (C) metastasis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 164</u> to <u>Aug 30</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 30</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <u>Charles L MacMinn</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | <u>Sept 7, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. Charles MacMinn | | 2900 E. Baltimore Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/9/66 | | Moreland Memorial Park | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 9 1966 | | <u>Robert J. ...</u> | | Schimunek Funeral Home, Inc. 2601 E. Madison St. | |



SAB-46-89-671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. **66 09097**

BIRTH NO. **66 09097**

M.E. CASE NO. **46-89-67**

1. NAME OF DECEASED
(Type or Print) **John (FISHER) URBANSKI**

2. DATE AND HOUR OF DEATH
9/8/66 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

5. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location)

SAB-46-89-671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. **66 09097**

BIRTH NO. **66 09097**

M.E. CASE NO. **46-89-67**

1. NAME OF DECEASED
(Type or Print) **John (FISHER) URBANSKI**

2. DATE AND HOUR OF DEATH
9/8/66 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

5. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location)

SAB-46-89-671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. **66 09097**

BIRTH NO. **66 09097**

M.E. CASE NO. **46-89-67**

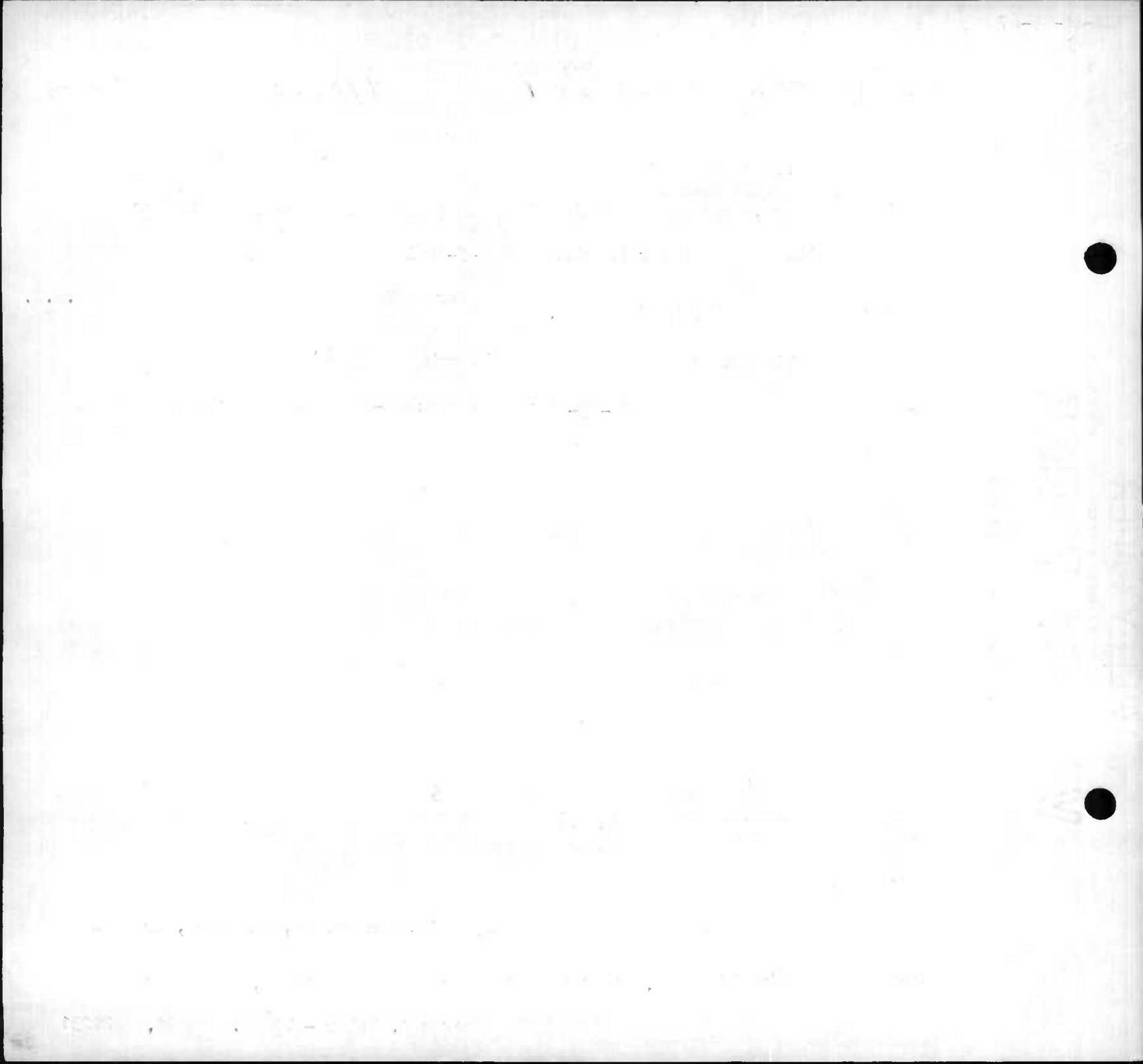
1. NAME OF DECEASED
(Type or Print) **John (FISHER) URBANSKI**

2. DATE AND HOUR OF DEATH
9/8/66 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

5. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location)



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R-262

66 09098

BALTIMORE CITY HEALTH DEPARTMENT

66 09098

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) Ruth Rogers | | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/6/66 6:30 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 601 Fremont Ave. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01 D. STREET ADDRESS (If rural, give location) 601 Fremont Ave. | | | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 2-8-1906 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Greensboro N. Carolina | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13. FATHER'S NAME Isaiah Downey | | | | 14. MOTHER'S MAIDEN NAME Jamie | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lucy Rogers | | ADDRESS | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/7/66 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9-8-66 | | 23C. NAME OF CEMETERY or CREMATORY Beaumont | | 23D. LOCATION (City, town, or county) (State) North Carolina | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 24B. NAME OF REGISTRAR E. E. Taylor | | 24C. FUNERAL DIRECTOR Sheppard & Bone N. Carolina | | | |

WALLER FORGE

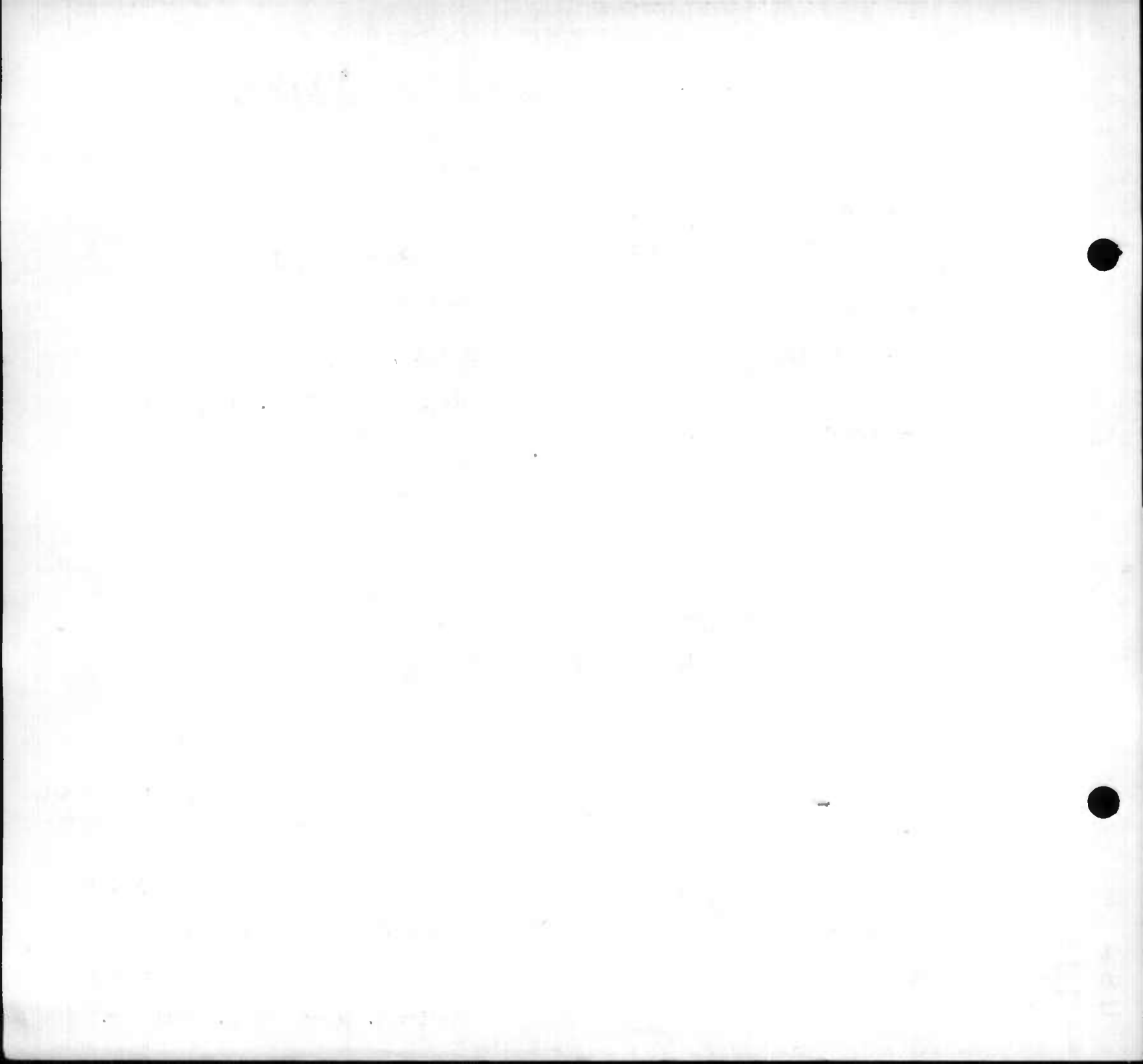
W. A. JENNIFER

W. A. JENNIFER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 66 09099 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09099 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Martha Baker</i> | | | 9/8/66 12 ²⁰ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | A. STATE <i>Baltimore, Maryland</i> | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Maryland</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>1323 N. Dallas St.</i> | | |
| 5. SEX <i>7</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>8/1/06</i> | 9. AGE (In years last birthday) <i>60</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State of foreign country) <i>Virginia</i> | |
| 13. FATHER'S NAME <i>Floyd Booker</i> | | | 14. MOTHER'S MAIDEN NAME <i>Turbin, Rose</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Robert Baker 1323 N. Dallas Street</i> | |
| 18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiovascular Disease</i> | | | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> 19 <i>66</i> to <i>9/8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Herman H. Gold</i> M.D. | | | | 23B. DATE SIGNED <i>9/8/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Herman Gold</i> M.D. | | | | 23D. ADDRESS <i>The Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/12/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Buckingham County, Virginia</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>William C. March 928 E. North Ave.</i> | |



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B-143
V-332

66 09100

BALTIMORE CITY HEALTH DEPARTMENT

66 09100

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Boblitz
Frances Veditz

2. DATE AND HOUR PRONOUNCED DEAD

9/6/66 10:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

622 Cator Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

622 Cator Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Jan. 6, 1900

9. AGE (In years last birthday)

66 65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sewing Operator retired (BVD Corp.)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Phila., Penna.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-10-5080

17. INFORMANT

ADDRESS

Jane Veditz 622 Cator Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) First, second and third degree burns over 50% of body surface

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

622 Cator Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9 6 66 7:30 a.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Smoking in bed while under influence of barbiturates.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/6/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/8/66

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 9 1966

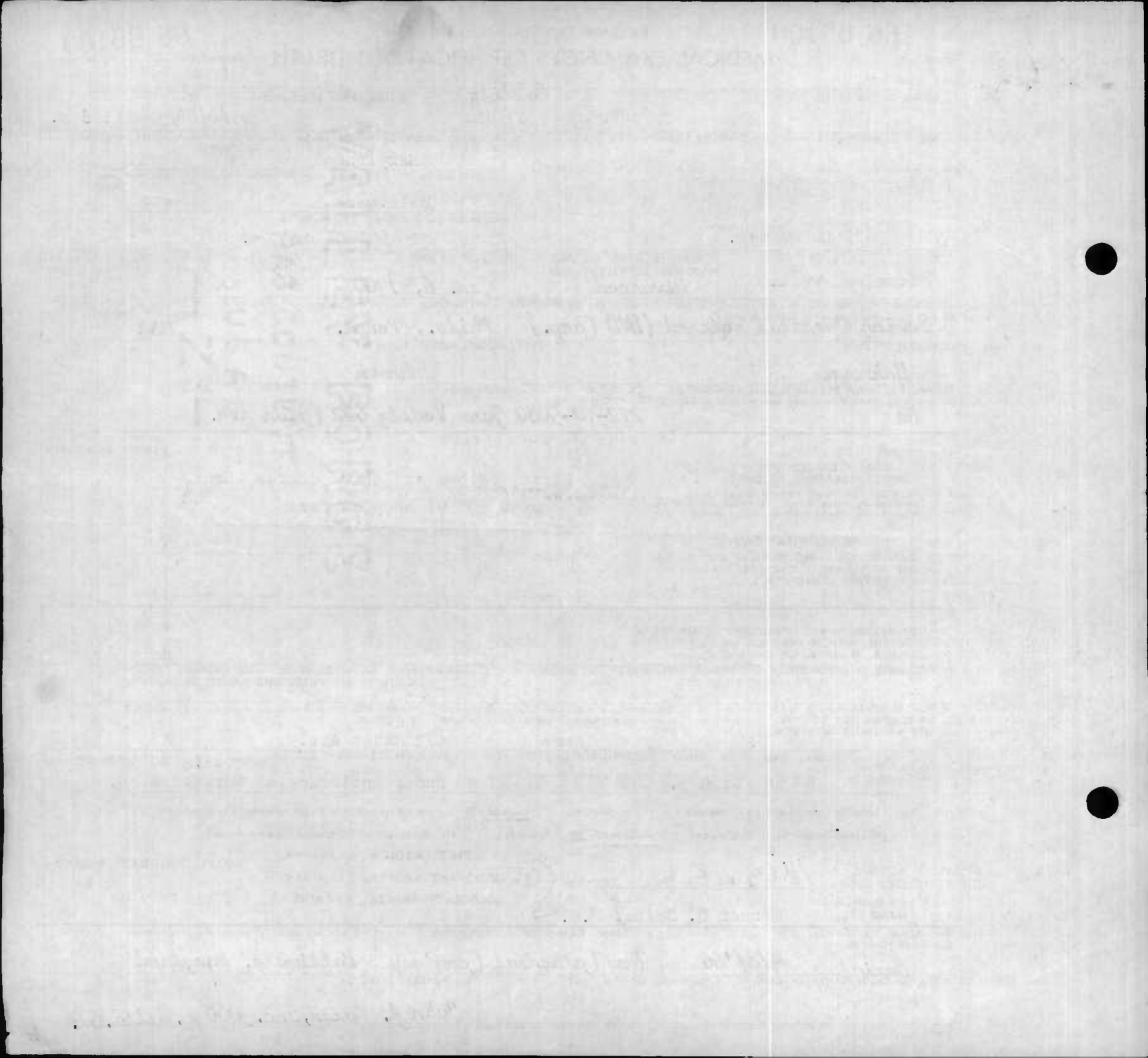
24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

ADDRESS



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VV623

66 09101 BALTIMORE CITY HEALTH DEPARTMENT 66 09101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **WILLIAM G. WRIGHT Jr** 2. DATE AND HOUR PRONOUNCED DEAD **September 7, 1966 8:05 P M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **2234 W. Fayette Street** 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) **Maryland** A. STATE B. COUNTY **20-02**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Jan 21-1907** 9. AGE (In years last birthday) **59** 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Lab** 10B. KIND OF BUSINESS OR INDUSTRY **North Carolina** 11. BIRTHPLACE (State or foreign country) **North Carolina** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **William Wright Sr** 14. MOTHER'S MAIDEN NAME **Sallie Hines**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **166-111-1111** 17. INFORMANT **Ilda Mae Wright** ADDRESS **Same**

18. **443 X I** CAUSE OF DEATH **Hypertensive Cardiovascular Disease.** INTERVAL BETWEEN ONSET AND DEATH _____

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **9/8/66**

EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **9-10-66** 23C. NAME of CEMETERY or CREMATORY **North Eastern Cemt** 23D. LOCATION (City, town, or county) (State) **Pocky Mount & C**

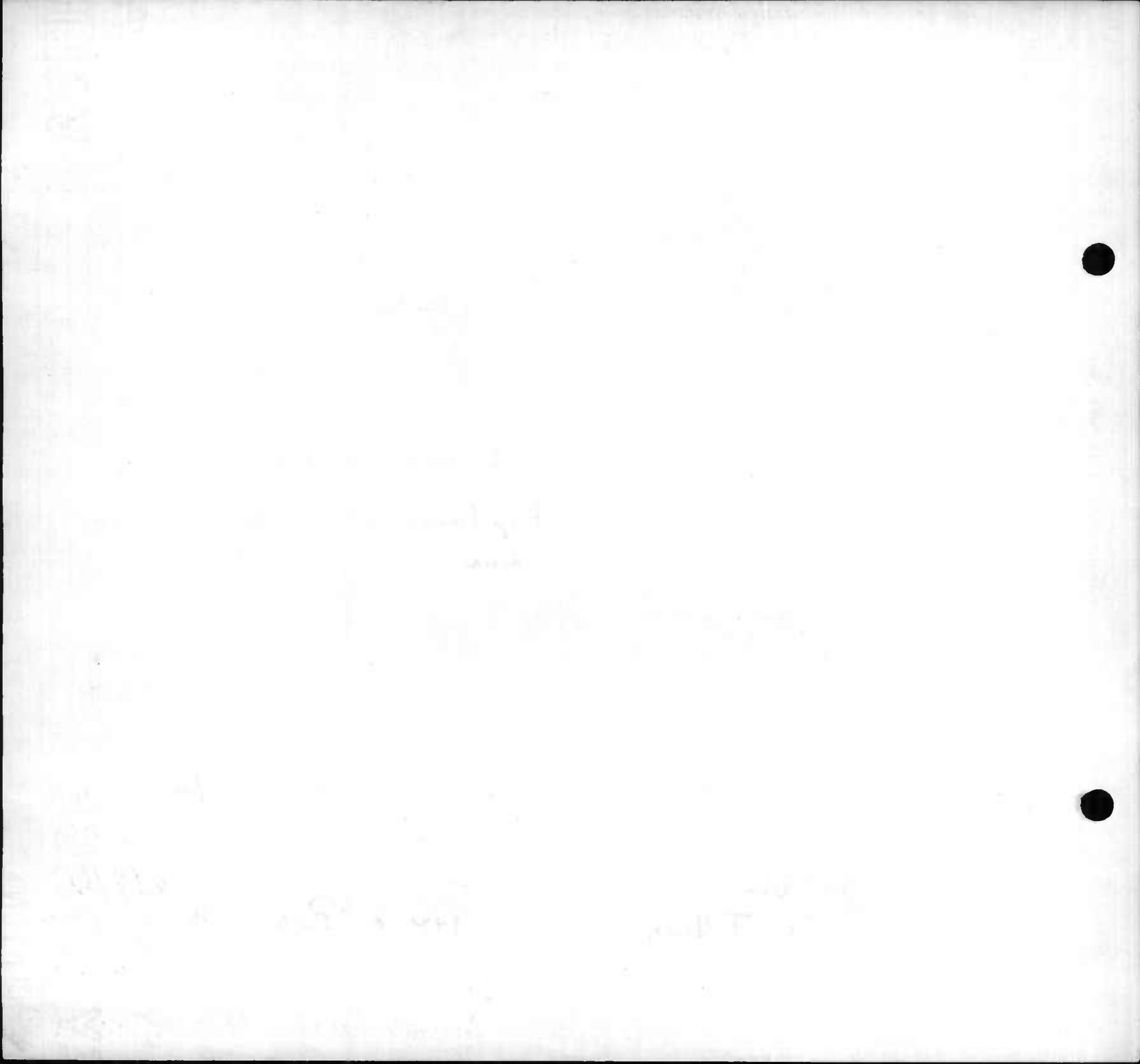
24A. DATE REC'D BY HEALTH DEPT. **SEP 9 1966** 24B. NAME OF REGISTRAR **Robert E. Stokes** 24C. FUNERAL DIRECTOR **C.C. Stokes** ADDRESS **h c**

WALL
POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|---|---|--|--|
| BIRTH NO. 66 09102 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09102 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Marie Stevenson | | | Sept. 2, 1966 9 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 121 N. Chapel St. | | | A. STATE Maryland B. COUNTY 6-04 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 121 N. Chapel St. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Dec. 15, 1916 | 9. AGE (in years last birthday) 49 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Winnaboro, S. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Cliff Woodland | | | 14. MOTHER'S MAIDEN NAME Riley Sawyer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-16-3914 | 17. INFORMANT Jamar Stevenson | | ADDRESS same |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ant. cardiac dilatation | | | CAUSE OF DEATH (A) ant. cardiac dilatation DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Hypertensive cardiac vascular disease DUE TO | | 10 yrs |
| | | | (C) diabetes | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1 1966 to 9/2 1966, that (I) (we) last saw the deceased alive on 9/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. C. Feldman | | | | 23B. DATE SIGNED 9/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) S. C. Feldman | | | | 23D. ADDRESS 1440 E. Belts St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Vista Cem. | |
| 24D. LOCATION (City, town, or county) (State) Winnaboro S. Carolina | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Feldman | | 25C. FUNERAL DIRECTOR Alexander Russell | | | |
| 25D. ADDRESS Winnaboro, S. C. | | | | | |



66 09103

66 09103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

LEON W. JAMES

2. DATE AND HOUR PRONOUNCED DEAD

September 1, 1966 2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

11-15-66

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1517 W. Lombard St
109 S. Stricker Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 5, 1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

A. H. James

14. MOTHER'S MAIDEN NAME

LIZZIE Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

229-05843

17. INFORMANT

ADDRESS

DAISY Gregory 1517 W. Lombard St

18.

E 900.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO Bronchopneumonia
Fracture of neck

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1525 W. Lombard Street

21D. TIME OF INJURY
(APPROX.)

July 17, 1966 2:00 A

21E. INJURY OCCURRED

WHILE AT

NOT WHILE AT

WORK

WORK

21F. HOW DID INJURY OCCUR?

Fell down steps

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURECharles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 10/66

23C. NAME of CEMETERY or CREMATORY

American Legion

23D. LOCATION (City, town, or county)

Appalachia

(State)

Va

24A. DATE REC'D BY HEALTH DEPT.

SEP 9, 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

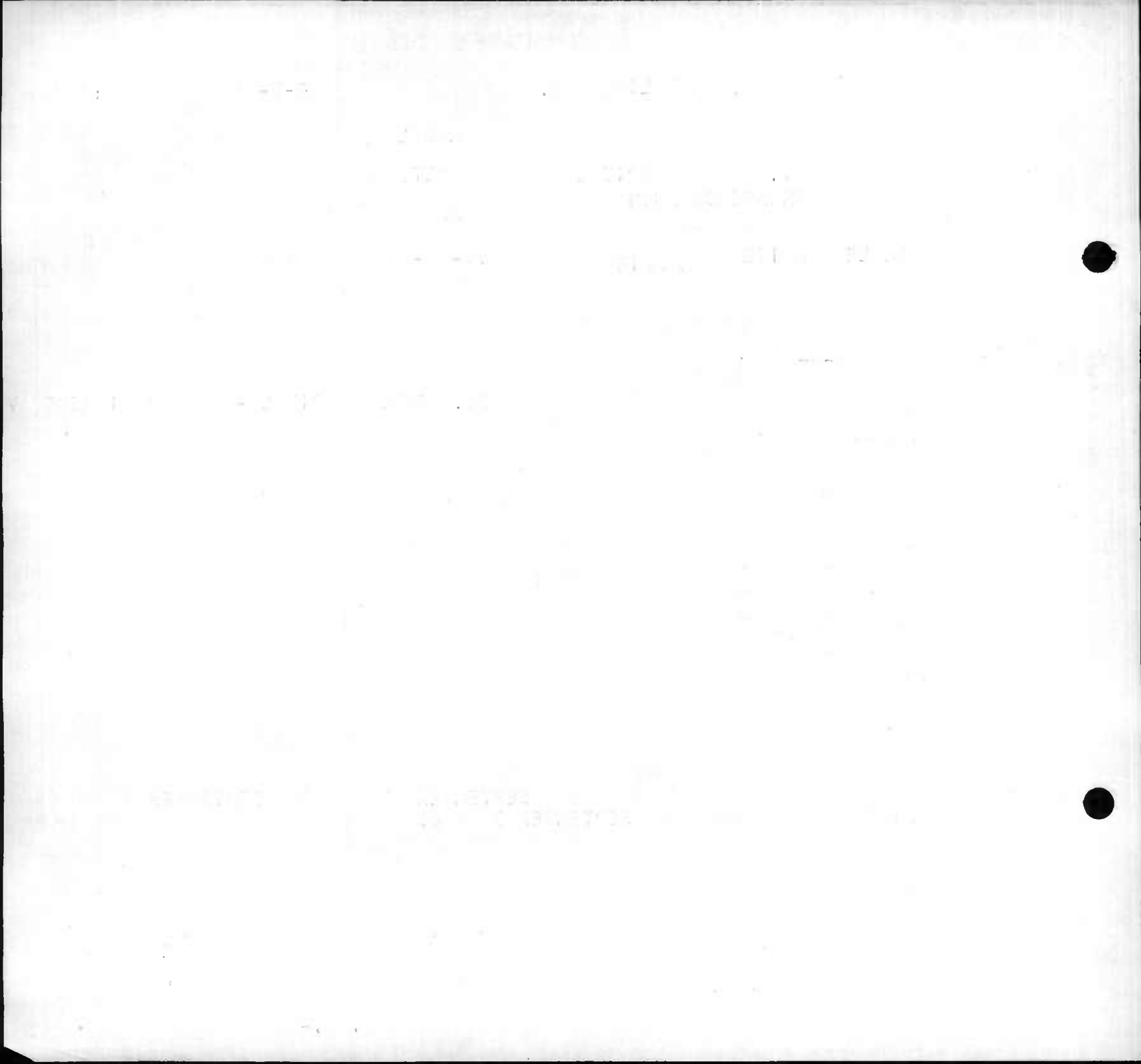
W. H. - 4101 Edmondson Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

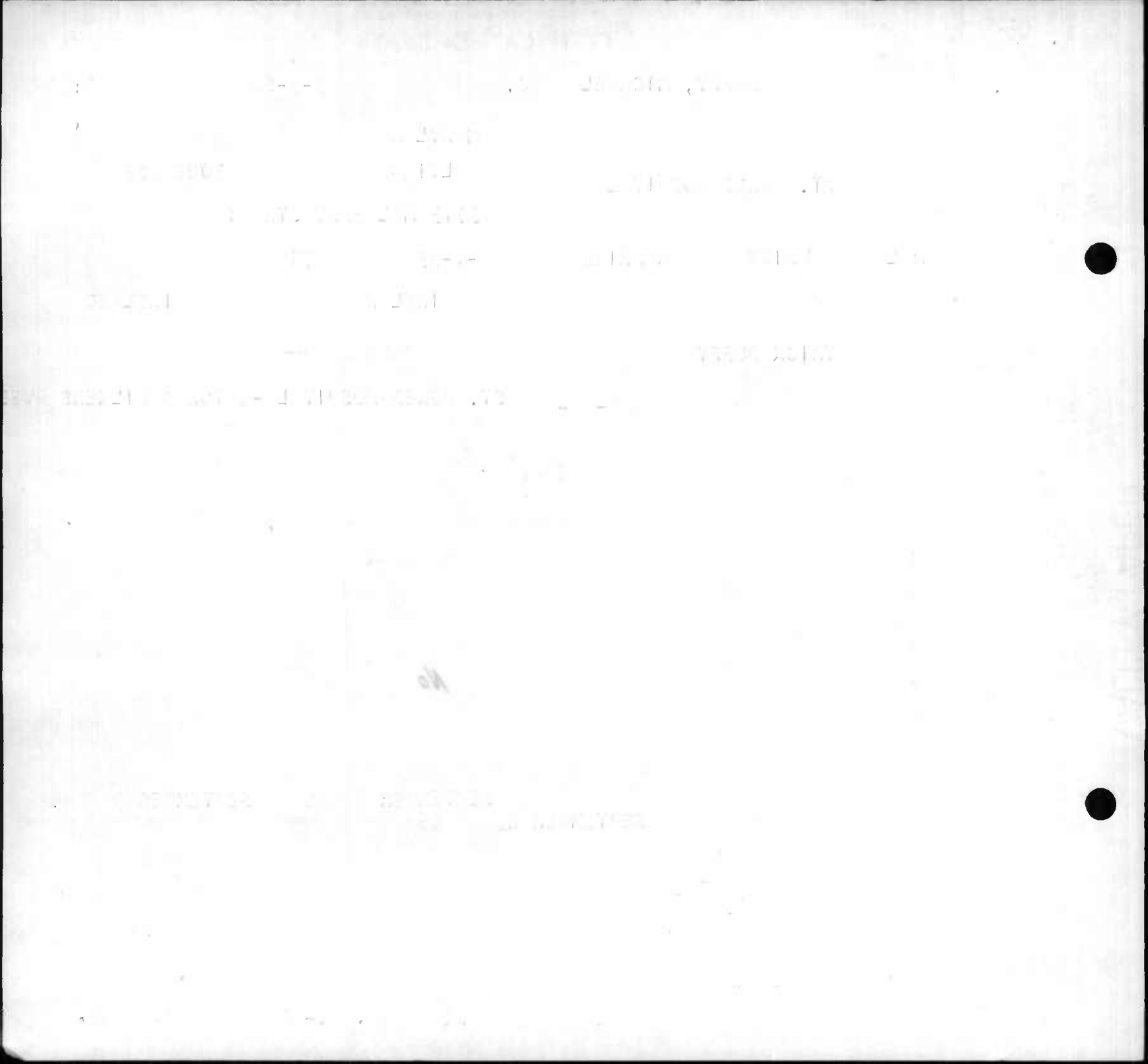
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09104 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 66 09104 | | M.E. CASE NO. 66 09104 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SAGHY, MADELINE E. | | | 2. DATE AND HOUR OF DEATH 9-7-66 9:00P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL EMERGENCY ROOM | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2556 SOUTHDENE AVE | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-30-16 | 9. AGE (In years lost birthday) 49-59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME -----Mills | | | 14. MOTHER'S MAIDEN NAME Bessie Huff | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ST. AGNES HOSPITAL -CATON & WILKENS AV | |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the Breast with metastases & extension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 7 19 66 to SEPTEMBER 7 19 66 , that (I) (we) last saw the deceased alive on SEPTEMBER 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Peter Stasiowski | | | | 23B. DATE SIGNED 9-8-66 | |
| 23C. PHYSICIAN'S NAME (Type) M. Peter Stasiowski | | | | 23D. ADDRESS St. Agnes Hospital Caton & Wilkens Aves. 29 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-10-66 | | 24C. NAME OF CEMETERY or CREMATORY Western Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09105 | |
|--|---------------|--|-------------------------|--|-----------------------------|
| BIRTH NO. 66 09105 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) DUFFY, MICHAEL J. | | 2. DATE AND HOUR OF DEATH 9-9-66 3:00A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 29 D. STREET ADDRESS (If rural, give location) 3713 MULBERRY STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-1-95 | 9. AGE (In years last birthday) 71 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) IRELAND | |
| 13. FATHER'S NAME PATRICK DUFFY | | 12. CITIZEN OF WHAT COUNTRY? IRELAND | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-07-6503 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 6, 1966 to SEPTEMBER 9, 1966, that (I) (we) last saw the deceased alive on SEPTEMBER 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| 23A. SIGNATURE | | 23B. DATE SIGNED 9-5-66 | | 23C. PHYSICIAN'S NAME (Type) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Witzke F. D.-4101 Edmondson Av. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|---|------------------|--|--|
| 66 09106 | | CERTIFICATE OF DEATH | | 66 09106 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | GEORGE E. HELFRICH | | | |
| 2. DATE AND HOUR OF DEATH | | 9/8/66 12:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland Baltimore Balto | | | |
| Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson 53-00 | | | |
| 37 | | D. STREET ADDRESS (If rural, give location) 8213 Thornton Rd. 21204 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Married | Feb. 28, 1900 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Teacher | | Loyola High School | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Albert I. Helfrich | | Barbara Basel | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WW 1 | | 218-40-1019 | | Mrs. Philomena Helfrich 8213 Thornton Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | ACUTE MYOCARDIAL INFARCTION | | 2 days | |
| ANTECEDENT CAUSES | | (B) DUE TO | | YEARS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | CHRONIC OBSTRUCTIVE AIRWAY DISEASE | | YEARS | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | YES | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/7 19 66 to 9/8 19 66, that (I) (we) last saw the deceased alive on 9/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Bruce Gerber, M.D. | | | | 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| S. BRUCE GERBER, M.D. | | | | 8045 WOODGATE CR., BALTO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-12-66 | | Holy Redeemer Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 9 1966 | | Wm. Cook-Brooks Towson Inc. | | 1050 York Rd. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>288 09107</u> | |
|--|---------------------|--|-------------------------------------|--|---|
| BIRTH NO. <u>66 09107</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Carl John Anderson</u> | | 2. DATE AND HOUR OF DEATH <u>9/6/1966</u> <u>8 A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lake Drive Nursing Home</u> <u>2401 Eutam Place</u> <u>DALTON, Md.</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Cecil</u> <u>RD 4 Elkton Md.</u> <u>57-00</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Rural, Elkton</u> D. STREET ADDRESS (If rural, give location) <u>R.D. 4</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify) | 8. DATE OF BIRTH <u>8/6/1875</u> | 9. AGE (In years last birthday) <u>91</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Sweden</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John Anderson</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellna</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-07-8791</u> | | 17. INFORMANT <u>D.M. Cangara - 2401 Eutam Place</u> | |
| 18. <u>491 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Broncho pneumonia</u> (B) <u>DUE TO</u> (C) <u>DUE TO</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Chronic Brain Syndrome</u> | | <u>Seizure</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-10-</u> 19 <u>66</u> to <u>9-6-</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-6-</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Cesar Valle Cervero</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9-6-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u> | | 23D. ADDRESS M.D. <u>8629 Liberty Rd.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/9/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Elkton Cemetery</u> | |
| 24D. LOCATION <u>Elkton Cecil Co. Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Grant Funeral Home</u> | |
| | | | | ADDRESS <u>Box 22 North East, Md.</u> | |

No.

Box 100 of 100

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Continued from page 1
Box 100 of 100
Continued from page 1

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R-263

66 09108

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09108

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARSHALL

RICHARDSON

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1966

6:20 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2804 Roslyn Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3-19-1897

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Wash Richardson

14. MOTHER'S MAIDEN NAME

Elizabeth Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWI

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mildred Richardson 312 R St N.W. DC

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple severe injuries

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Liberty Heights & Grantley Avenue 15-11

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9-2-66

5:52

A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-8-66

23C. NAME of CEMETERY or CREMATORY

Arlington Nat.

23D. LOCATION

(City, town, or county)

(State)

Arlington Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 9

1966

Robert E. Taylor

H.S. Washington & Sons

4925 Denae Ave N.E. DC

WALTER D. BRYANT

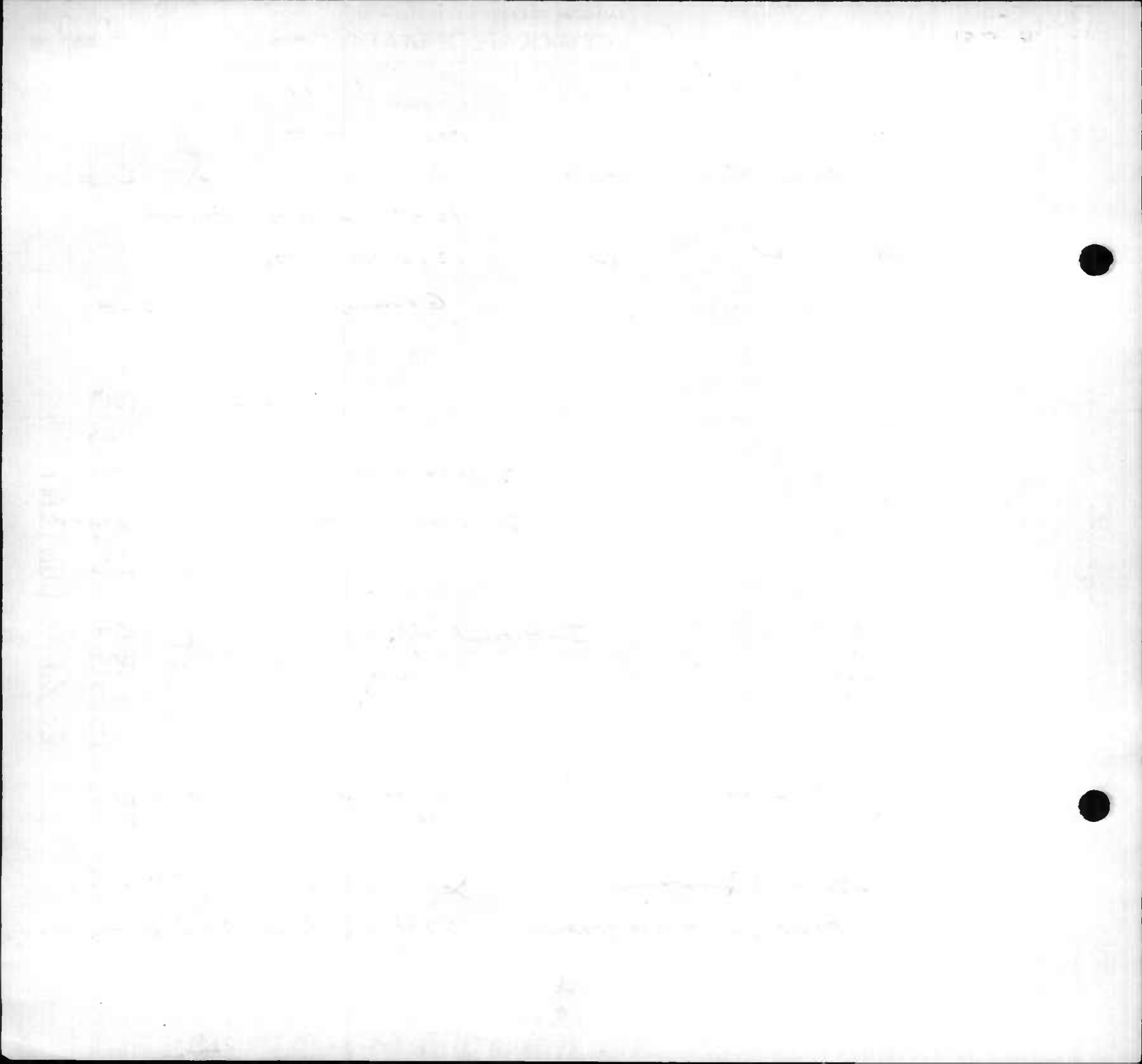
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12-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09109 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09109 | |
|---|------------------|--|---|--|--|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Paul O. Burkhardt | | | 9/8/66 7:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | | A. STATE MD B. COUNTY | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | D. STREET ADDRESS (If rural, give location) 1624 Lonsing Avenue | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 12/8/94 | 9. AGE (In years last birthday) 71 | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Serviceman Retired | | | 11. BIRTHPLACE (State or foreign country) Germany | | |
| 13. FATHER'S NAME Otto Burkhardt | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 216 03 6482 | | |
| 17. INFORMANT ADDRESS 1622 E. Cold Spring Lane | | | Mrs Gertrude Beaudet | | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I | | | (A) DUE TO Hypoglycemia know | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO Diabetes mellitus years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) Intestinal flu 10 hr | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from years 499 to 9/8/66 19 66 that (I) (we) last saw the deceased alive on 9/7/19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Marion Friedman M.D. | | | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN M.D. | | | | 23D. ADDRESS 5211 Hartford Road Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redemmer | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09110 | |
|--|-----------------------------|--|------------------------------------|---|---|
| BIRTH NO. 66 09110 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MAMIE A. Kern | | 2. DATE AND HOUR OF DEATH 9/8/66 1 7 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 305 Birkwood Pl. | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 6-11-87 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Cornelius W. Thomas | | 14. MOTHER'S MAIDEN NAME Mary Farrell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-01-4413 | | 17. INFORMANT ADDRESS Ruth Kern Frazier, 305 Birkwood Pl. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) Rupture of Myocardium (B) Transmural Myocardial infarction (C) Arteriosclerotic Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 days. ? years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | |
| 19A. DATE OF OPERATION 2 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS IN CERTIFYING CAUSES OF DEATH? YES | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. HOW DID INJURY OCCUR? — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (He) (this hospital) attended the deceased from 9/2/66 19 66 to 9/8 19 66 , that (I) (we) last saw the deceased alive on 9/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Philip B. Groskin | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) Philip B. Groskin | | 23D. ADDRESS M.D. — | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Frazier | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |

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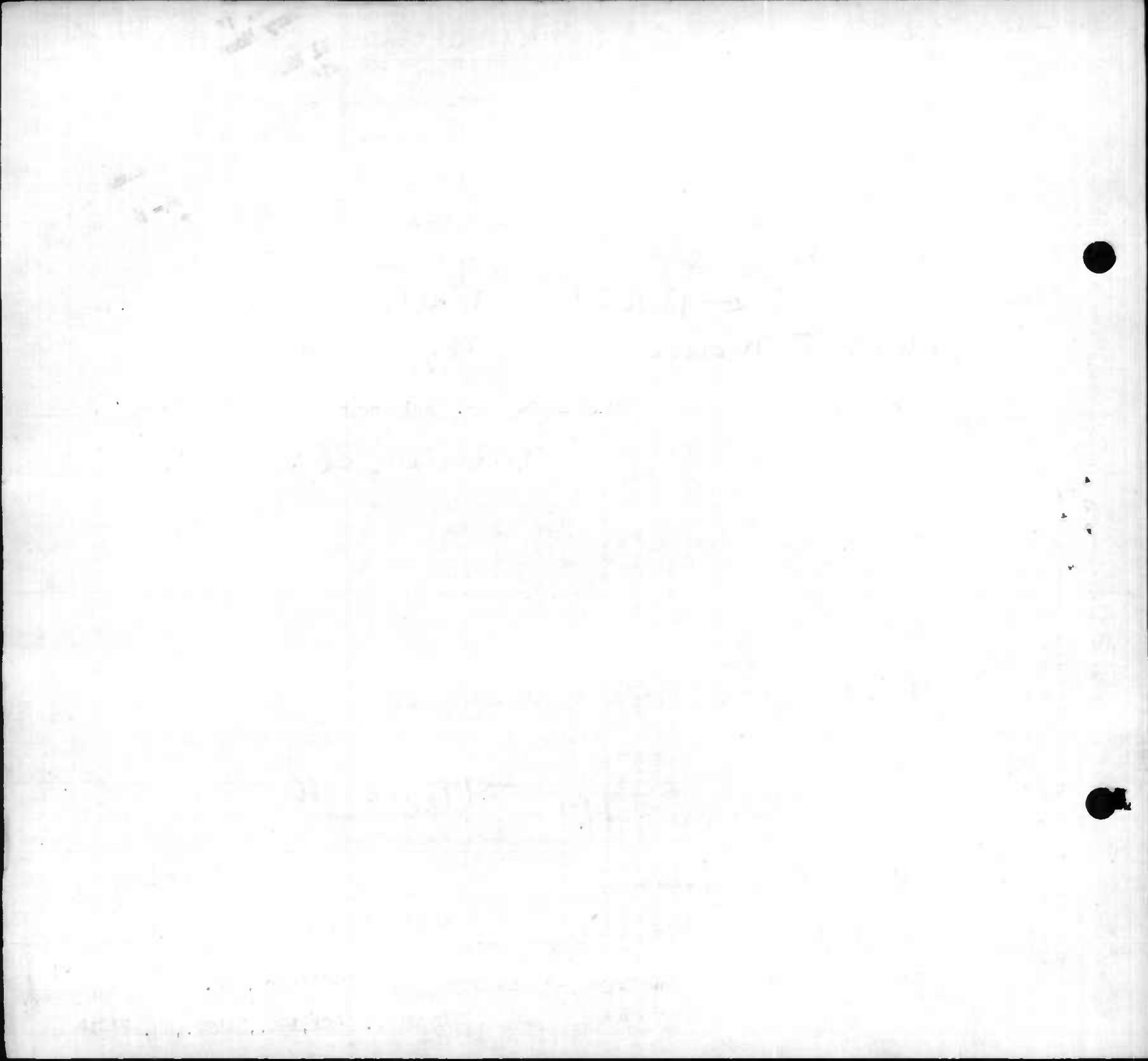
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09111 | |
|--|--------------|---|---|--|---|
| BIRTH NO. 66 09111 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 66 09111 | | | | | |
| 1. NAME OF DECEASED (Type or Print) William J Moran | | 2. DATE AND HOUR OF DEATH 8 PM (9/7/66) M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 18MD. GENERAL HOSPITAL | | A. STATE B. COUNTY B md. Baeto Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baeto | | | |
| | | D. STREET ADDRESS (If rural, give location) 6101 Alta Ave. 27-05 | | | |
| 5. SEX m | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep. | 8. DATE OF BIRTH 6/4/94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Relief | | 11. BIRTHPLACE (State or foreign country) Baeto md | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Wm J. Moran | | | 14. MOTHER'S MAIDEN NAME Cegner Cocori | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-26-4984 | | 17. INFORMANT Mr. Paul Moran | |
| | | | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH (A) DUE TO Metastatic co bleed | | INTERVAL BETWEEN ONSET AND DEATH 6 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/9/66 to 9/7/66, that (I) (we) last saw the deceased alive on 9/7/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel C Wilkerson M.D. | | | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) Daniel C Wilkerson M.D. | | | | 23D. ADDRESS 421 Degeet or Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR SEP 9 1966 | | 25C. FUNERAL DIRECTOR LEONARD J. BUCK, INC., BALTO., MD. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09112</u> | |
|---|-------------------------|--|--------------------------------------|---|---|
| BIRTH NO. <u>66 09112</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>AMELIA HOLTMAN</u> | | 2. DATE AND HOUR OF DEATH <u>9/7/66</u> <u>1</u> <u>P</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Gould Convalesarium</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore (East Twin River Beach) 5300</u> D. STREET ADDRESS (If rural, give location) <u>East Twin River Beach</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>10/7/1882</u> | 9. AGE (In years last birthday) <u>83</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Augustus Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Bertha Ryan</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mr. John P. Holtman RFD 14 Box 56 Balto. 20</u> | |
| 18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>Arteriosclerotic Heart Disease</u> DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>66</u> to <u>Sept</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert J. Lyden</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/9/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN</u> | | 23D. ADDRESS <u>6402 GOLDEN RING RD. BALTMOR.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/10/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 9 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. 5305 Harford Rd.</u> | |

17

MA

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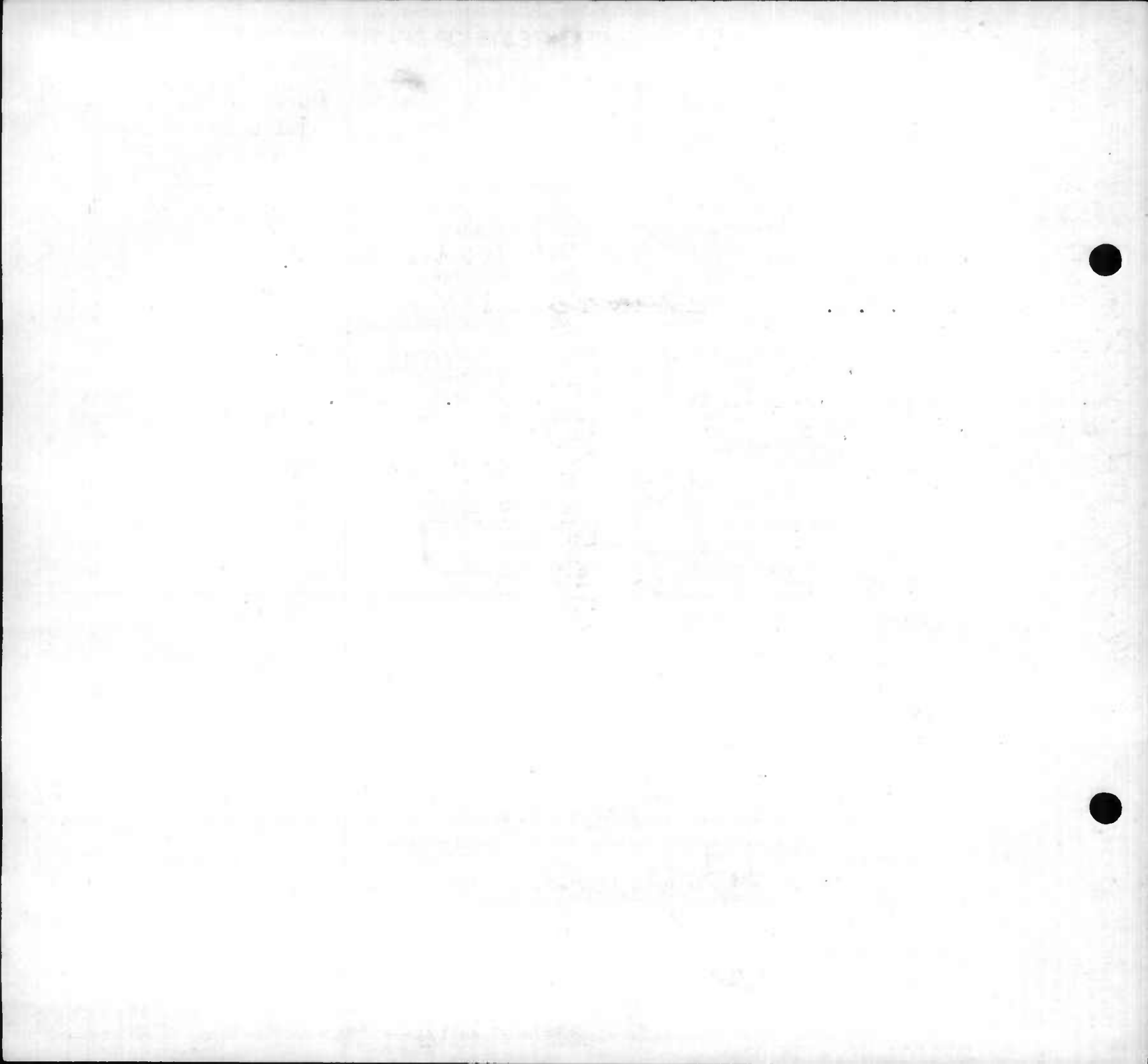
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Body released by Dr. Spitz, Baltimore
FUNERAL DIRECTOR: IMPORTANT: City Coroner's Office
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| 66 09113 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09113 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 7 Sept. 1966 8:30 P.M. | | | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | | |
| 38 UNIVERSITY HOSPITAL | | Maryland Baltimore | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Male | | Cau. | | Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| P. H. D. | | University of Maryland | | 26 Nov. 1916 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Adrian Robinson | | Alma Tenneson | | 49 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes World War II | | | | Mrs. Carolyn E. Robinson same address | |
| 18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Aortic Insufficiency | | | |
| ANTECEDENT CAUSES | | 5 B E | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 7 Sept. 1966 | | Aortic Valve prosthesis | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 20 June 1966 to 7 Sept 1966 that (I) (we) last saw the deceased alive on 7 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Delvin S. Santos, M.D. | | | | 7 Sept. 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Delvin S. Santos | | | | Univ. of Md. Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Cremation | | 9/9/1966 | | Greenmount Crematory | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 9 1966 | | R. E. F. F. F. | | Wm. J. F. F. F. | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | ADDRESS | |
| Baltimore, Maryland | | | | Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

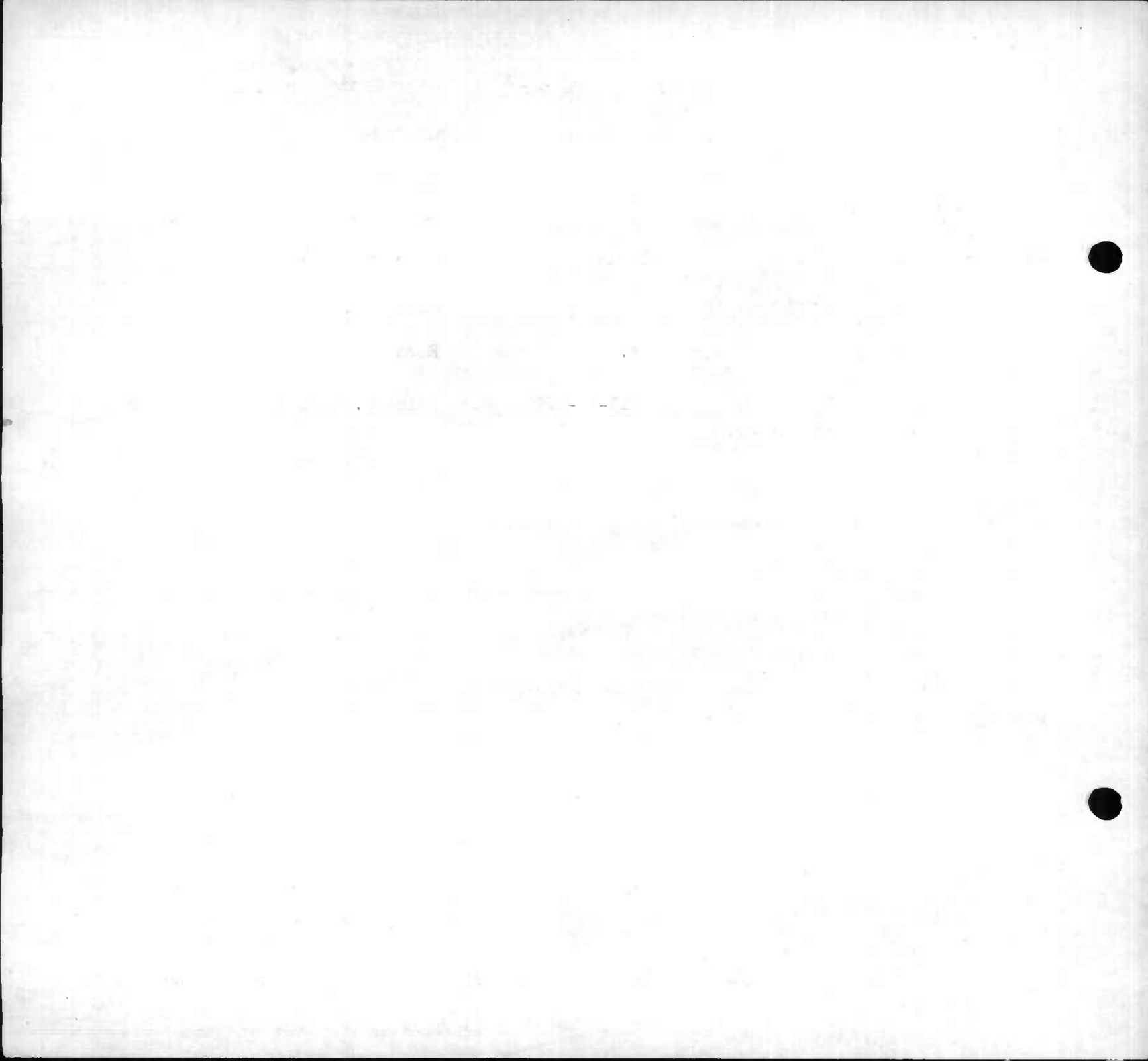
| Baltimore City Health Department | | | | Registered No. 66 09114 | |
|---|---------------------|--|--------------------------------------|---|---|
| BIRTH NO. 66 09114 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Catherine Fike</i> | | 2. DATE AND HOUR OF DEATH <i>9/7/66 3:00 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i> Md. </i> B. COUNTY <i> 4-02 </i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>102 N. Paca.</i> | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>unk.</i> | 8. DATE OF BIRTH <i>4/19/1902</i> | 9. AGE (In years last birthday) <i>64</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>unk.</i> | | 13. FATHER'S NAME <i>George Sipple</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Baer</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>CVA</i> <i>H CVD</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <div style="border: 1px solid black; padding: 5px; width: fit-content;">NOT A MEDICAL EXAMINER'S CASE <i>10/19/66</i> <i>R. M. [Signature]</i> M.D. CHIEF OR ASST. MEDICAL EXAMINER</div> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>he</i> (this hospital) attended the deceased from <i>7/7</i> 19 <i>66</i> to <i>9/7</i> 19 <i>66</i> , that <i>we</i> last saw the deceased alive on <i>9/7</i> 19 <i>66</i> and that <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>we</i> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Bernard du Buy</i> M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/7/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Bernard du Buy</i> M.D. | | 23D. ADDRESS <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>9/8/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Union Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Meyersdale, Pa.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 9 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i> | | 25C. FUNERAL DIRECTOR <i>Wm. J. [Signature]</i> | |
| | | | | ADDRESS <i>North Va Ave Balto, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

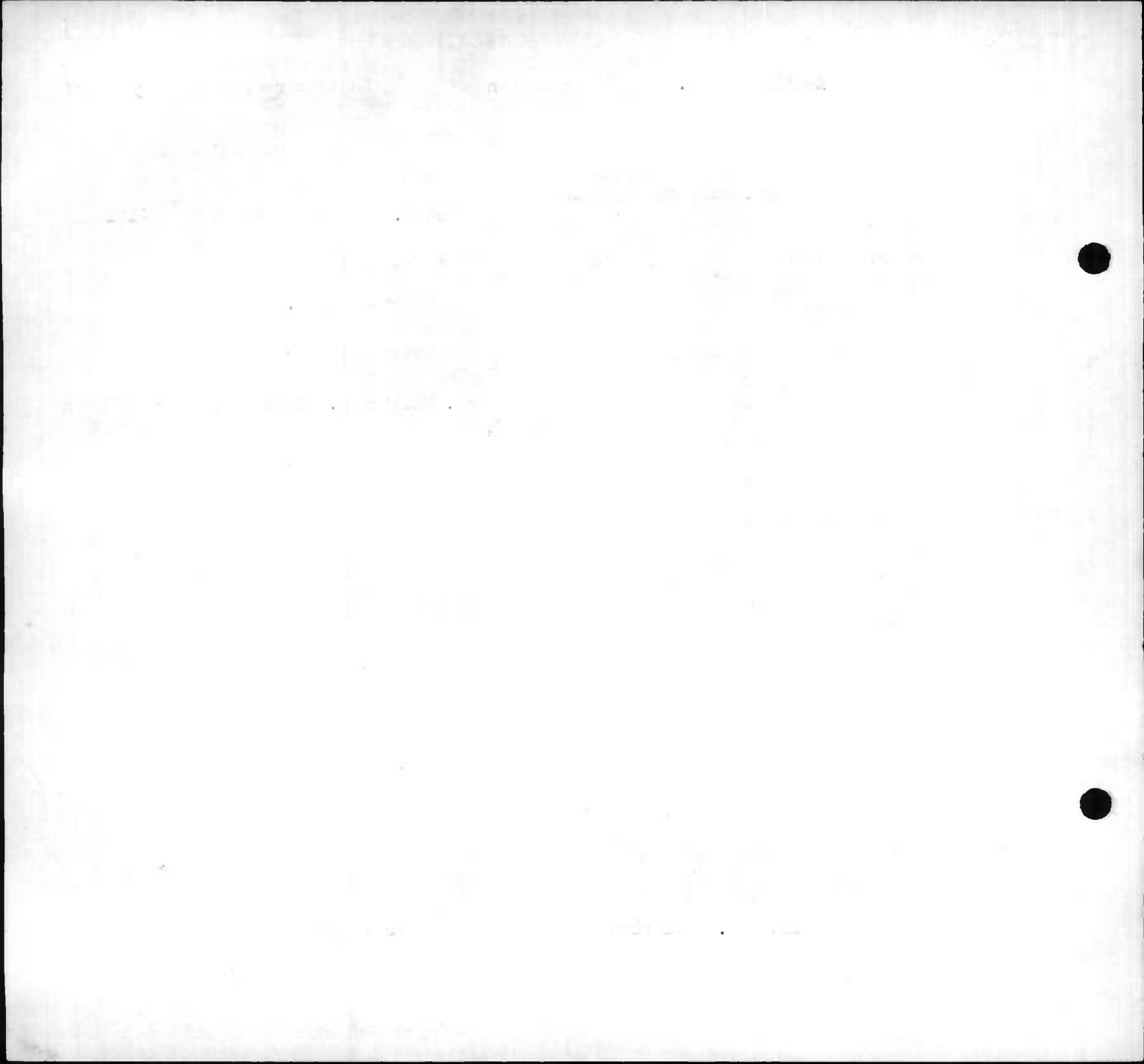
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09115 | |
|---|---------|--|---|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 66 09115 | |
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Rose Freida Wagner | | September 7, 1966 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Mercy Hospital | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, give RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 4414 Marble Hall Road 18 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| Female | White | Single | April 25, 1890 | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Never worked | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Frederick Wagner Sr. | | | Bosa Meyer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No None | | 213-48-0294 | | Miss Reina G. Wagner same address | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| CAUSE OF DEATH | | | 30 minutes | | |
| (A) ACUTE PULMONARY EDEMA | | | | | |
| (B) ASCVD | | | | | |
| (C) | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | DISSEMINATED RETICULUM CELL SARCOMA 2 years | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 none | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| no | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/27/66 19 to Sept. 7 19 66, that (I) (we) last saw the deceased alive on Sept 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| James A. Quinlan, Jr. | | | | Sept 7, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JAMES A. QUINLAN, JR. | | MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/10/1966 | | Baltimore Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 9 1966 | | R. E. F. F. F. | | Wm J. Fickner Sons Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09116 | |
|--|---------|--|--------------------------|---|-------------------------------|
| 66 09116 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Loutie M. Robertson | | September 8, 1966 | | 5 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 210 East Belvedere Avenue Baltimore, Maryland 21212 | | | | A. STATE Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 210 E. Belvedere Avenue 21212 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Female | White | Married | March 21, 1889 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Homemaker | | | | Baltimore, Md. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William Meissel | | | Laura Moore | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No None | | | | Mrs. William H. Richardson same address | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ACUTE PULMONARY EDEMA | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | |
| | | | | (B) DUE TO | |
| | | | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 8 1966 to Sept 1966. that (I) (we) last saw the deceased alive on Sept 8 1966 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William C. Helfrich | | | | 23B. DATE SIGNED Sept 9 '66 | |
| 23C. PHYSICIAN'S NAME (Type) William C. Helfrich | | | | 23D. ADDRESS 5006 Roland Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/1966 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 9 1966 | | 25B. NAME OF REGISTRAR Robert E. Lasker | | 25C. FUNERAL DIRECTOR Donna J. Lasker | |
| | | | | ADDRESS Baltimore Md. Donna J. Lasker | |



1
B-610

66 09117

BALTIMORE CITY HEALTH DEPARTMENT

66 09117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES LEWIS BARBEE

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1966 9:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

500 ft. Span Hanover Street side.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If not, give location)

1121 N. CAROLINE ST.
836 E. Preston Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

8-7-26 40-27

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Ship Yard

11. BIRTHPLACE (State or foreign country)

Durham N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES WW #2

16. SOCIAL
SECURITY NO.

17. INFORMANT

Fred'k Barbbee

ADDRESS

Durham
N.C.

18. E929.81

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

?

25-32

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
? ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Found in water presumably drowned

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 6, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/12/66

23C. NAME OF CEMETERY or CREMATORY

BALTO. HGT.

23D. LOCATION

(City, town, or county)

(State)

5501 Fred'k Ave

24A. DATE REC'D BY HEALTH DEPT.

SEP 9

24B. NAME OF REGISTRAR

R. E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Elliott

ADDRESS

FUNERAL HOME

Boat Police Station
Boat Police Station

1
J-300

66 09118

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09118

| | | | |
|---|---------|--|------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| Charles G. Judy | | 9/5/66 7:57 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| 43 South Baltimore General Hospital | | Maryland | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 1018 Light St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH |
| male | white | Married | 3/9/32 |
| 9. AGE (In years last birthday) | | 10. BIRTHPLACE (State or foreign country) | |
| 34 | | Baltimore, Md. | |
| 11. CITIZEN OF WHAT COUNTRY? | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Charles G. Judy | | Martha Sponglar | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Yes 152 - 154 | | 220 24 1402 | |
| 17. INFORMANT | | ADDRESS | |
| Mrs. Shirley Judy | | 1018 Light St. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E976X Gunshot wound of head (A) DUE TO | | | |
| II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | | |
| III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| yes | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | home | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. HOW DID INJURY OCCUR? | |
| 1014 Light St. | | shot self in head | |
| 21E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21F. HOW DID INJURY OCCUR? | |
| 9 5 66 6:30 p. M. | | shot self in head | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | DATE SIGNED | |
| Werner U. Spitz, M.D. | | 9/6/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 9/9/66 | |
| 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Baltimore National Cem. | | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| SEP 12 1966 | | Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| JOHN F. DENNY, INC. | | 715 Light St. | |

17856.4 66091180

WALLACE RUGER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09119 | |
|---|-----------|---|-----------------------------|--|-------------------------------------|
| BIRTH NO. 66 09119 | | CERTIFICATE OF DEATH | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) GRACE L. DIMAN | | 2. DATE AND HOUR OF DEATH 3:40 PM / 5-Sept 1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Charles | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION HOSPITAL 7 UNIVERSITY MARYLAND | | C. CITY OR TOWN Cobb Island 5800 | | | |
| D. STREET ADDRESS MARYLAND CHARLES CO. | | E. CITY OR TOWN | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 9/20/16 | 9. AGE (In years last birthday) 79 | 10. AGE (In years last birthday) 79 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Elizabeth, New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William F. Loveland | | | |
| 14. MOTHER'S MAIDEN NAME BELMAH SCHWARTZ | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 579-26-3326 | | 17. INFORMANT ADDRESS Mr. Sidney H. Diman-Cobb Island, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) F. S. H. D. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Operation: Pacemaker implanted | | 20. CAUSE OF DEATH VENTRICULAR FIBRILLATION - 2 days Perforation of Ventricle by Pacemaker cable - 4 wks | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 22. MEDICAL CERTIFICATION | | | |
| 23. DATE OF OPERATION 5 Sept 66 | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED Ventricular fibrillation & Co | | 25. AUTOPSY? (Yes or No) Yes | |
| 26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 27. DATE OF INJURY 9 5 66 | | | |
| 28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital | | 30. WHERE DID INJURY OCCUR? Univ. of Md. 4-02 | |
| 31. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 5 66 | | 32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 33. HOW DID INJURY OCCUR? Heart Perforation by catheter | |
| 34. I certify that (I) (this hospital) attended the deceased from 5 Sept 66 to 5 Sept 66, that (I) (we) last saw the deceased alive on 5 Sept 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 35. SIGNATURE R. P. WENZEL | | | |
| 36. DATE SIGNED 5 Sept 66 | | 37. PHYSICIAN'S NAME (Type) R. P. WENZEL | | | |
| 38. ADDRESS UNIVERSITY HOSPITAL | | 39. DATE 9/8/1966 | | | |
| 40. NAME OF CEMETERY or CREMATORY Cedar Hill Crematory | | 41. LOCATION (City, town, or county) (State) Suitland, Maryland | | | |
| 42. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 43. NAME OF REGISTRAR John E. Jenkins | | 44. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc. - La Plata, Md. | |

R. P. WENZEL

TRIMMER

University of Nevada
College

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FUNERAL DIRECTOR: IMPORTANT

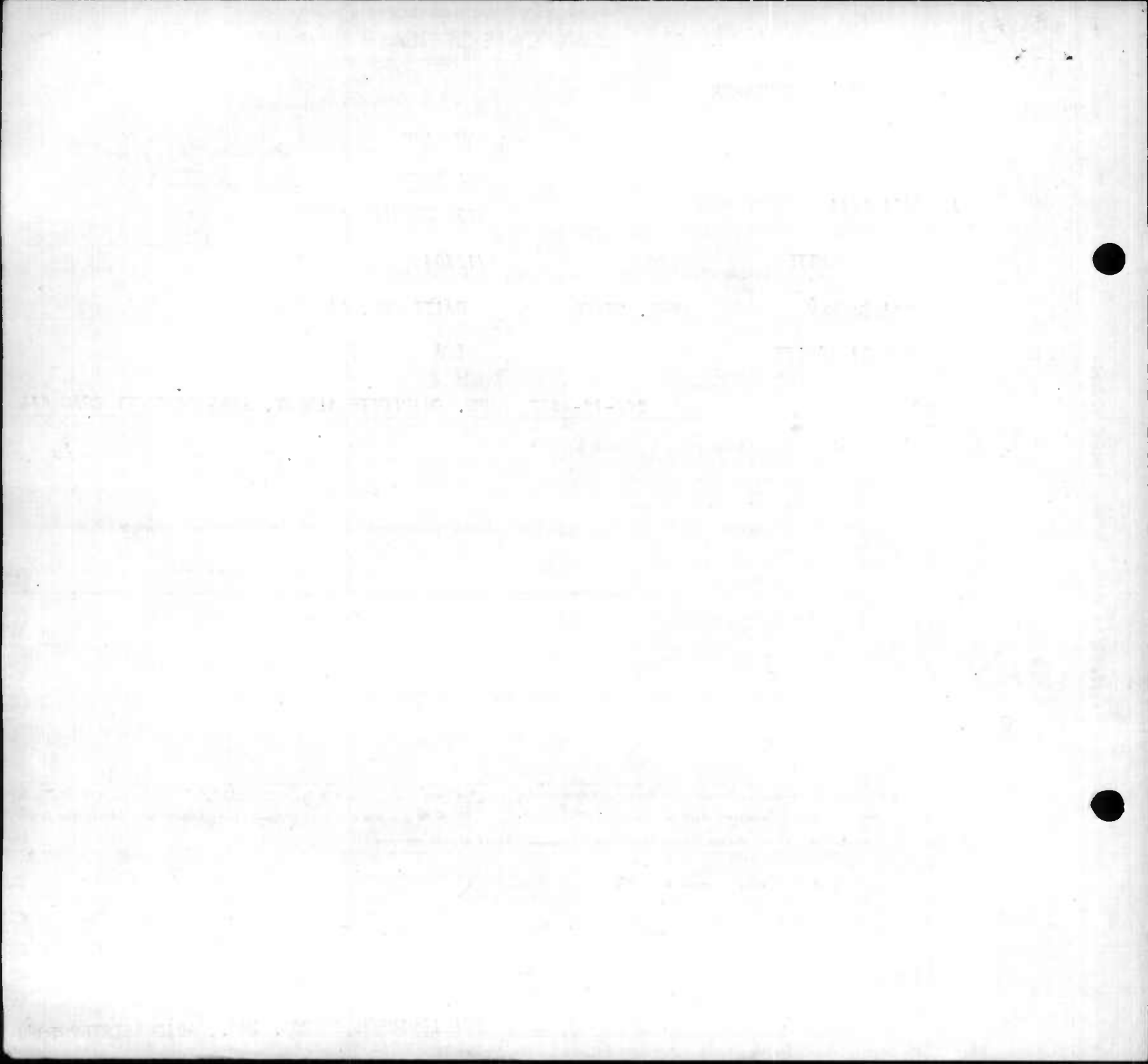
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. <u>66 09120</u> |
|---|-------------------------|---|---|---|
| BIRTH NO. <u>66 09120</u> | | M.E. CASE NO. <u>66 09120</u> | | |
| 1. NAME OF DECEASED (Type or Print) <u>Bernard Bettelman</u> | | 2. DATE AND HOUR OF DEATH <u>September 7, 1966</u> <u>12</u> P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>3306 Market Rd.</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u> | 8. DATE OF BIRTH <u>6/26/12</u> | 9. AGE (In years lost birthday) <u>54</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store owner</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SHOE STORE</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, MARYLAND</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>NATHAN BETTELMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>ROSE BROZER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II ARMY</u> | | 16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u> | 17. INFORMANT ADDRESS <u>MRS. BELLE BETTELMAN 3306 MARNAT ROAD #8</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>42011-260X</u> | | CAUSE OF DEATH (A) <u>Cardiac Arrest</u> <u>10 hrs.</u> (B) <u>Myocardial Infarction</u> <u>10 hrs.</u> (C) <u>Arteriosclerotic Cardiovascular disease</u> <u>years</u> <u>Diabetes mellitus</u> <u>5 years</u> <u>Cerebrovascular Accident</u> <u>14 days</u> | | |
| 19A. DATE OF OPERATION <u>2 0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> | | |
| 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>0</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u> | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u> | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>0</u> | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>0</u> | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> 19 <u>66</u> to <u>9/7</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>9/7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Erwin H. Hesselberg</u> | | 23B. DATE SIGNED <u>Sept-7, 1966</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u> | | 23D. ADDRESS <u>Sinai Hospital of Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>9/8/66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>SHAAREI TFILOH</u> | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

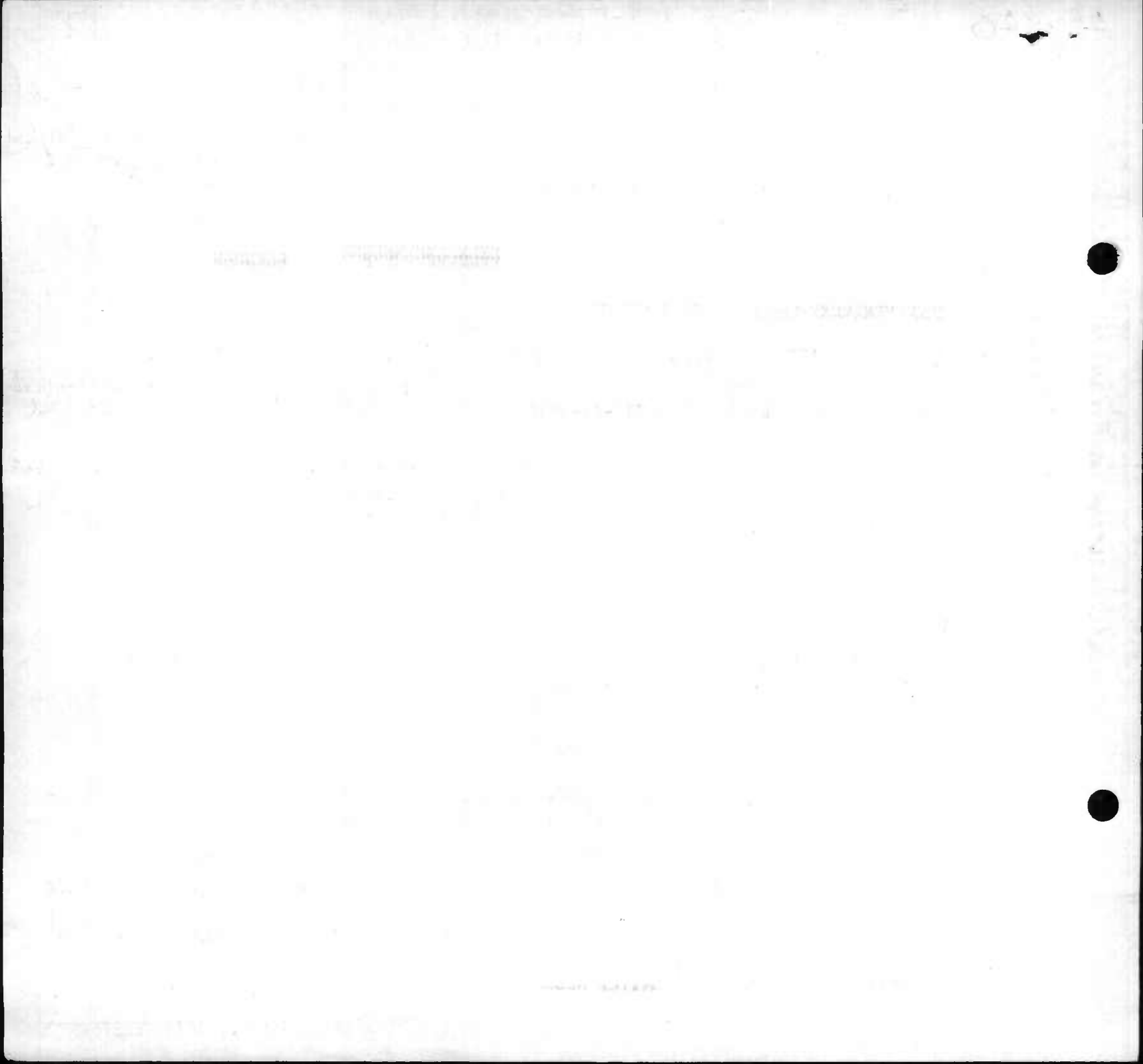
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 09121</u> | |
|---|----------------------|--|---------------------------------|--|----------------------------|--|--|
| BIRTH NO. <u>66 09121</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>TAMRES SARA</u> | | 2. DATE AND HOUR OF DEATH <u>9-8-66 6 59 AM</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4601 Pall Mall Rd</u> <u>90 PALL MALL NURSING HOME</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3733 BEEHLER AVENUE</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>9/12/04</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESWOMEN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>MICHAEL LEVITT</u> | | | | 14. MOTHER'S MAIDEN NAME <u>IDA ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-12-4807</u> | | 17. INFORMANT ADDRESS <u>MRS. CHARLOTTE ALBERT, 3706 BANCROFT ROAD #15</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of breast - metastases to liver</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO <u>none</u> (C) <u>none</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>none</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>64</u> to <u>Sept 8</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Manuel Levin</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/8/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u> M.D. | | | | 23D. ADDRESS <u>4818 Reisterstown Rd Balto Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/9/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>WORKMEN CIRCLE</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u> | | ADDRESS <u>6010 REISTERSTOWN</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 66 09122 | |
|---|----------------------|---|--|--|---|---|--|
| BIRTH NO. 66 09122 | | | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LEBOW, OSCAR | | | | 2. DATE AND HOUR OF DEATH 3:14 pm. Sept. 7, 1966 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Simai Hospital of Baltimore. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 6511 Brighton Ave. Baltimore, Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 6511 Brighton Ave. | | | |
| 5. SEX Male | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH XXXXXXXXXX 69 | 9. AGE (In years, last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Owner | | 10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME LEBOWITZ SAMUEL MOSES | | | | 14. MOTHER'S MAIDEN NAME FRIEDMAN, FANNY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I. 1917-1919 | | 16. SOCIAL SECURITY NO. 218-28-6950 | | 17. INFORMANT Herbert Martin Lebow. | | ADDRESS 3403 W. Strathmore Ave. Balt. Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Chronic Cachexia, secondary to Extensive Metastasis of Abdominal Carcinomatosis | | | | INTERVAL BETWEEN ONSET AND DEATH About 2 months (from onset of symptoms to death) | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION August 4, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Cecum | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 27, 1966 to Sept. 7, 1966 , that (I) (we) last saw the deceased alive on Sept. 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Luk Chang, Jang | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 7, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) SUK CHANG, JANGT | | | | 23D. ADDRESS M.D. Simai Hospital of Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY BOBROISKER VEREIN UNITED HEBREW | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC., | | ADDRESS 6010 REISTERSTOWN | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09123 | |
|--|---------|---|------------------|--|------------------------------|
| BIRTH NO. 66 09123 | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| NIVENS BABY BOY | | 2. DATE AND HOUR OF DEATH | | 8/30/66 12:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| CHAURCH HOME AND HOSPITAL | | BALT. | | 34 28-07 | |
| D. STREET ADDRESS (If rural, give location) | | 6819 McCLEAN BLVD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| M | W | | 8/29/66 | 2 | W.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | BALTIMORE Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| JAMES NIVENS | | JOAN FICACCI | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) Respiratory distress. | | | |
| ANTECEDENT CAUSES | | (B) bilateral atelectasis with early hyaline membrane disease. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) prematurity. | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 29th 1966 to Aug 30th 1966, that (I) (we) last saw the deceased alive on Aug 30th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| A. Ma hum. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | August 30, 66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | 9/2/66 | | ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 12 1966 | | R. E. Taylor, M.D. | | JOHNS HOPKINS MEDICAL SCHOOL | |
| | | | | MORTUARY SERVICE - BCHD | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|---|--|--|
| 66-18071 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09124 | |
| BIRTH NO. 66 09124 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type as Print) Baby Girl Wilkins | | 2. DATE AND HOUR OF DEATH 8/31/66 6:30 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balt | | M. | |
| FULL NAME OF (If not in hospital at institution, give street address or location) INSTITUTION Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balt | | 15-01 | |
| 33 | | D. STREET ADDRESS (If rural, give location) 1312 N. Stockton St | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 8/29/66 | 9. AGE (In years last birthday) 2 days | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Z | | 14. MOTHER'S MAIDEN NAME Iona White | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT BCH chart | | |
| 18. 75.5 T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Aortic Atresia + h. ventricular Congenital defect (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/31 1966 to 8/31 1966 that (I) (we) last saw the deceased alive on 8/31 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth I. Berns | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8/31/66 | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth I. Berns. | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 9/8/66 | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | |
| 24D. LOCATION (City, town or county) BALTIMORE | | 24E. LOCATION (State) MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE | |
| 25D. ADDRESS | | | | | |

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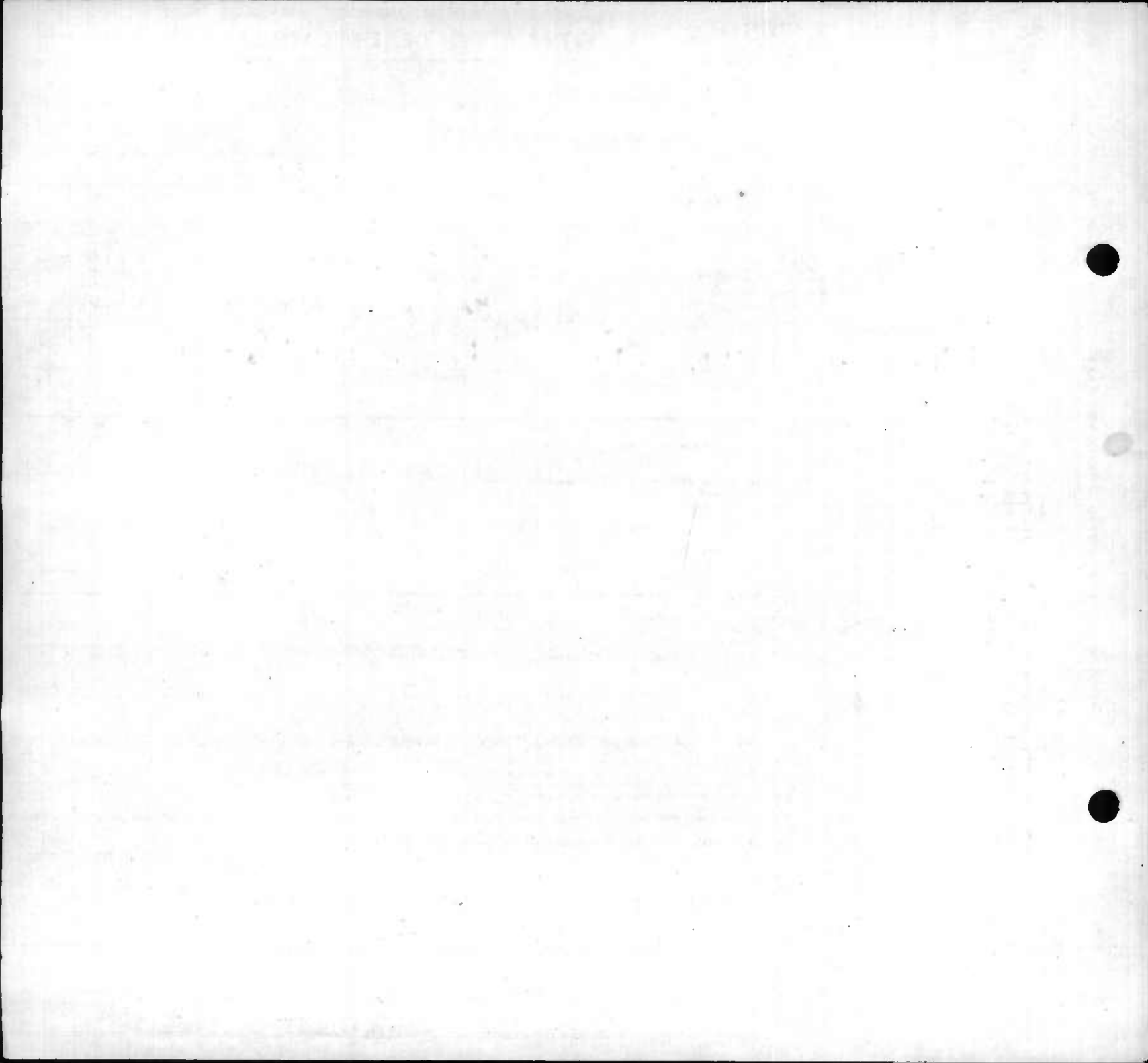
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|--|---|--|--|--|
| B-610 | | 66/157766 09125 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09125 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY BRUCE | | | | Aug 25 1966 15 ³⁰ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital 827 Linden Ave. | | | | A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 5300 D. STREET ADDRESS (If rural, give location) 2916 LIBERTY PKWAY. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH Aug 25 1966 | 9. AGE (In years last birthday) 9 YR 2 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALLACE Henry BRUCE | | | | 14. MOTHER'S MAIDEN NAME Nancy Ann Getty | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY | | | | CAUSE OF DEATH (A) RESPIRATORY FAILURE DUE TO (B) PREMATURITY DUE TO (C) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH 9 hr 25 min | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 9/2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8/25/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9/2/66 | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (Hotel) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Farkas, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 12 1966 MORTUARY SERVICE - BCHD | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09126 |
|--|---|--|--|---|
| BIRTH NO. 66 09126 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES LEO CHANEY | | 2. DATE AND HOUR OF DEATH SEPT. 6, 1966 7:00P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND B. COUNTY AA | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM 52-00 | | |
| | | D. STREET ADDRESS (If rural, give location) 556 CLEVELAND ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-17-18 | 9. AGE (In years last birthday) 48 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE | | 10B. KIND OF BUSINESS OR INDUSTRY BALTO. LIFE INS. | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME JOHN CHANEY (DEC'D) | | 14. MOTHER'S MAIDEN NAME MARTHA REIGLE (DEC'D) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2ND WORLD WAR | | 16. SOCIAL SECURITY NO. 220/07/5033 | | 17. INFORMANT ADDRESS HOSPITAL SLIP ST. AGNES HOSPITAL |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1810 I Uremia | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Advance Carcinoma of Urinary Bladder | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 9, 1966 to SEPTEMBER 6, 1966 , that (X) (we) lost saw the deceased alive on SEPTEMBER 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death. | | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED SEPT 6, 1966 |
| 23C. PHYSICIAN'S NAME (Type) DR. BORROMEO | | 23D. ADDRESS BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVE. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEPT. 10, 66 | | 24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEM'L PARK |
| 24D. LOCATION (City, town, or county) (State) HOWARD CO. MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS R.V. SINGLETON GLEN BURNIE, MD. |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09127 | |
|---|-----------|--|--------------------------------|--|--|
| BIRTH NO. 66 09127 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROSA B SMITH | | 2. DATE AND HOUR OF DEATH 9/4/66 4:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. Sinai Nursing Home. | | A. STATE Md. Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 3437 Greenmount Ave. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed. | 8. DATE OF BIRTH Sept. 13/1882 | 9. AGE (In years, lost birthday) 83 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own home. | | 11. BIRTHPLACE (State or foreign country) York Co., Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Houston | | 14. MOTHER'S MAIDEN NAME Sarah Strawbridge | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Violet Wilson, Md. Line, Md. | |
| 18. 422.1 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Cerebrovascular accident | | 1 day | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (B) arterio-sclerotic cv disease | | 15 yr | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 28, 1966 to Sept 4, 1966, that (I) (we) last saw the deceased alive on Sept 4, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Maurine Feldman | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/4/66 | |
| 23C. PHYSICIAN'S NAME (Type) MAURICE FELDMAN, JR. | | 23D. ADDRESS LATROBE BLDG., BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-7-66 | | 24C. NAME OF CEMETERY or CREMATORY New Freedom Cem. | |
| 24D. LOCATION (City, town, or county) New Freedom, York Co., Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Feldman | | 25C. FUNERAL DIRECTOR Jacob Hartenstein, New Freedom, Pa. | |

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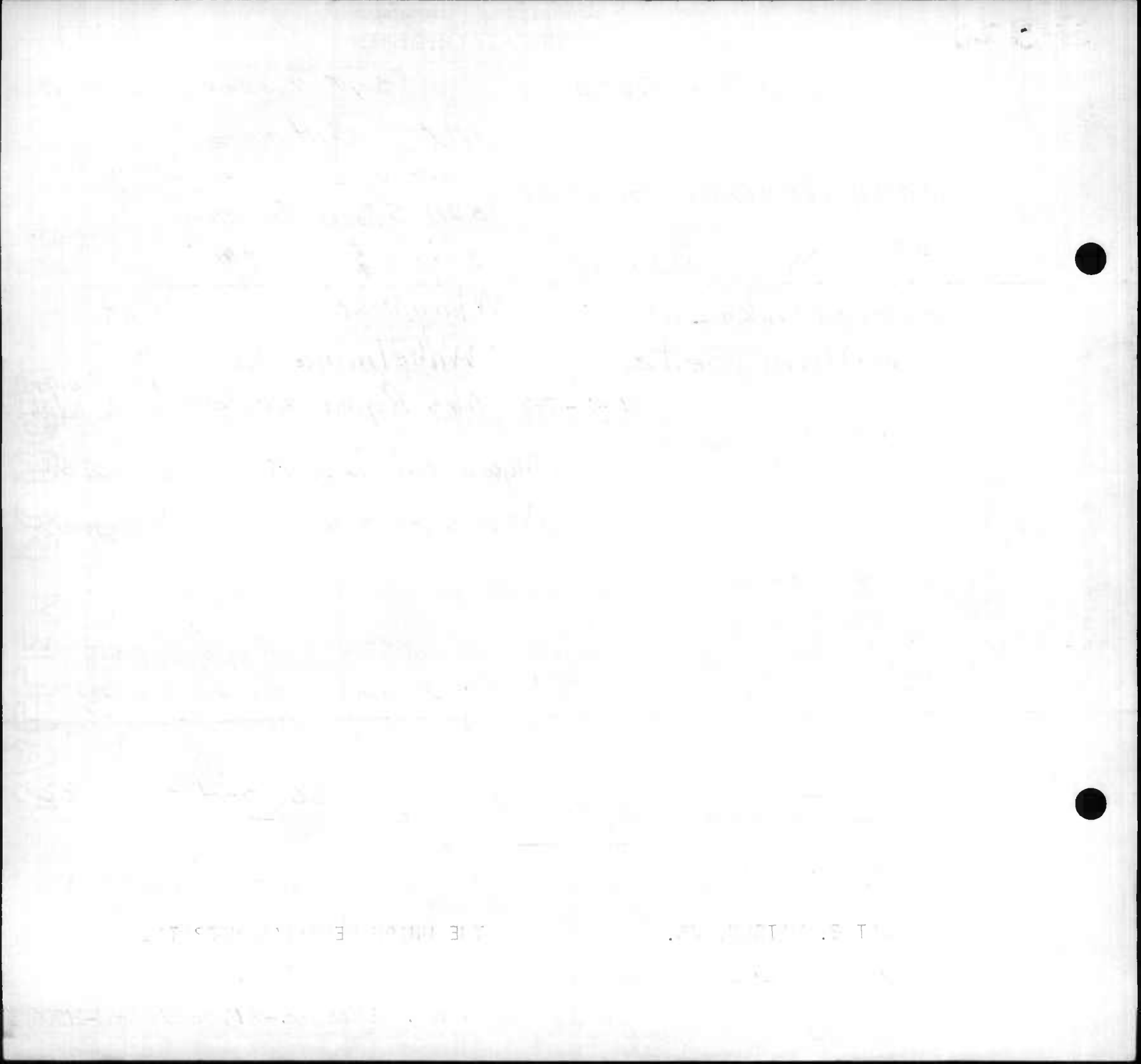
Wm. W. W. W. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09128 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09128 | |
|--|---------------------|---|--|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>John William Seitz</u> | | | 2. DATE AND HOUR OF DEATH <u>Sept 7, 1966</u> <u>12:40 P.</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> | | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>26-02</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>5211 5th Terrace</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>2/5/1892</u> | 9. AGE (In years last birthday) <u>74</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (unknown)</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>William Seitz</u> | | 14. MOTHER'S MAIDEN NAME <u>Wilhelmina Gessner</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-10-2792</u> | | 17. INFORMANT <u>Mrs Regina Krider</u> ADDRESS <u>104 Beaver Brook Rd #12</u> | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C) _____ | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>Many years</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>66</u> to <u>Sept 7</u> 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>Sept 7</u> 19 <u>66</u> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Nat E. Watson, Jr.</u> M.D. | | | | 23B. DATE SIGNED <u>Sept 7, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NAT E. WATSON, JR.</u> M.D. | | | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-10-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>John C. Miller, Inc.</u> ADDRESS <u>6415 Belair Road-21206</u> | |

SEP 12 1966



1
N-426
N-260

66 09129

BALTIMORE CITY HEALTH DEPARTMENT

66 09129

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

THOMAS NEWLOUSER

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1966 1:18 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

609 S. Robinson Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

5-24-1895

9. AGE (In years last birthday)

71

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Long Shoreman

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Friedrich

14. MOTHER'S MAIDEN NAME

Anna Dockle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-07-5061

17. INFORMANT

Mrs. Thelma Moll

ADDRESS

613 S. Robinson St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 7, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9-10-66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION

Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Thelma R. Hoffmann

ADDRESS

3218 Hudson St.

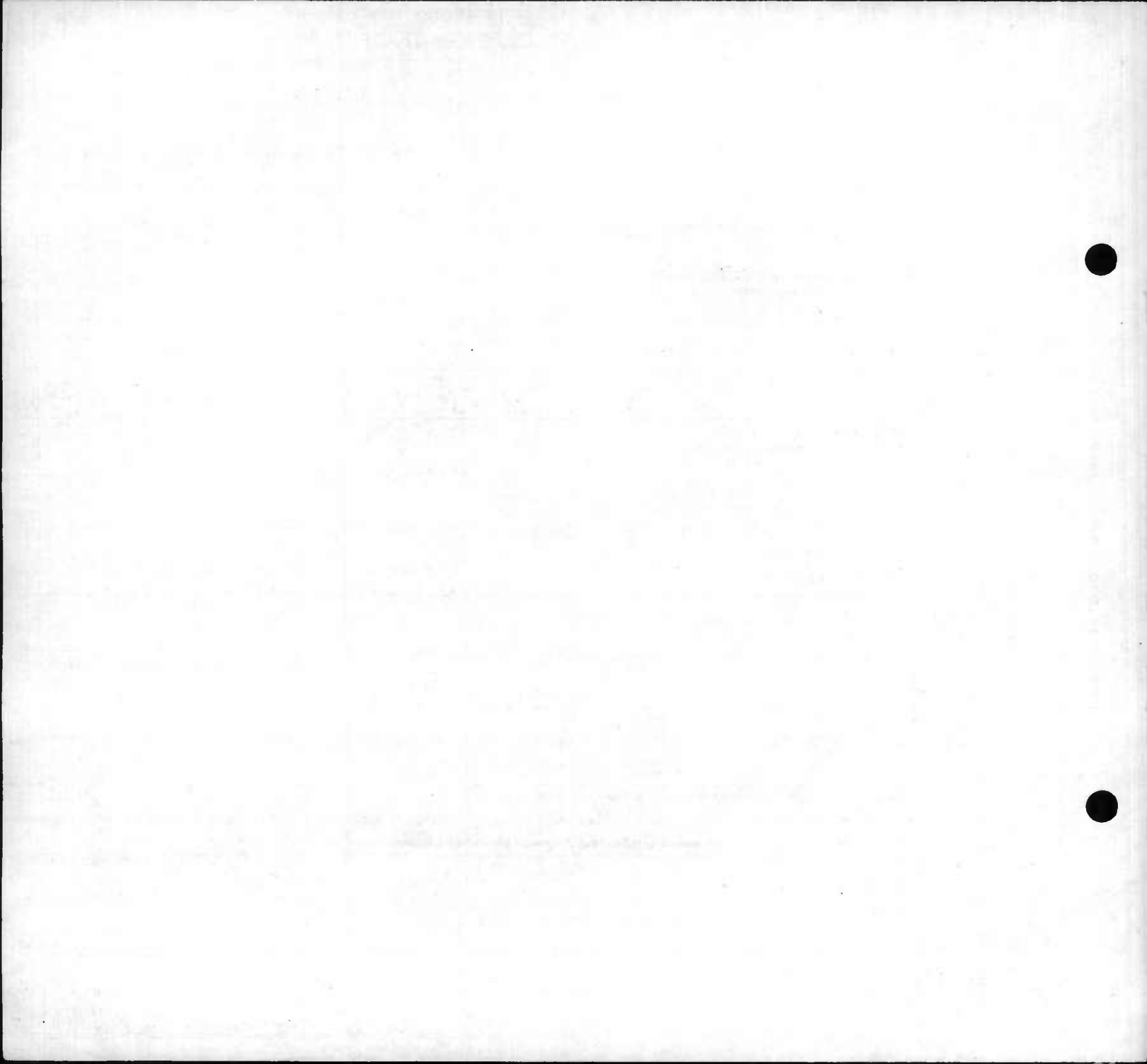
VALLEY FORGE

PROBATION

FUNERAL DIRECTOR: IMPORTANT

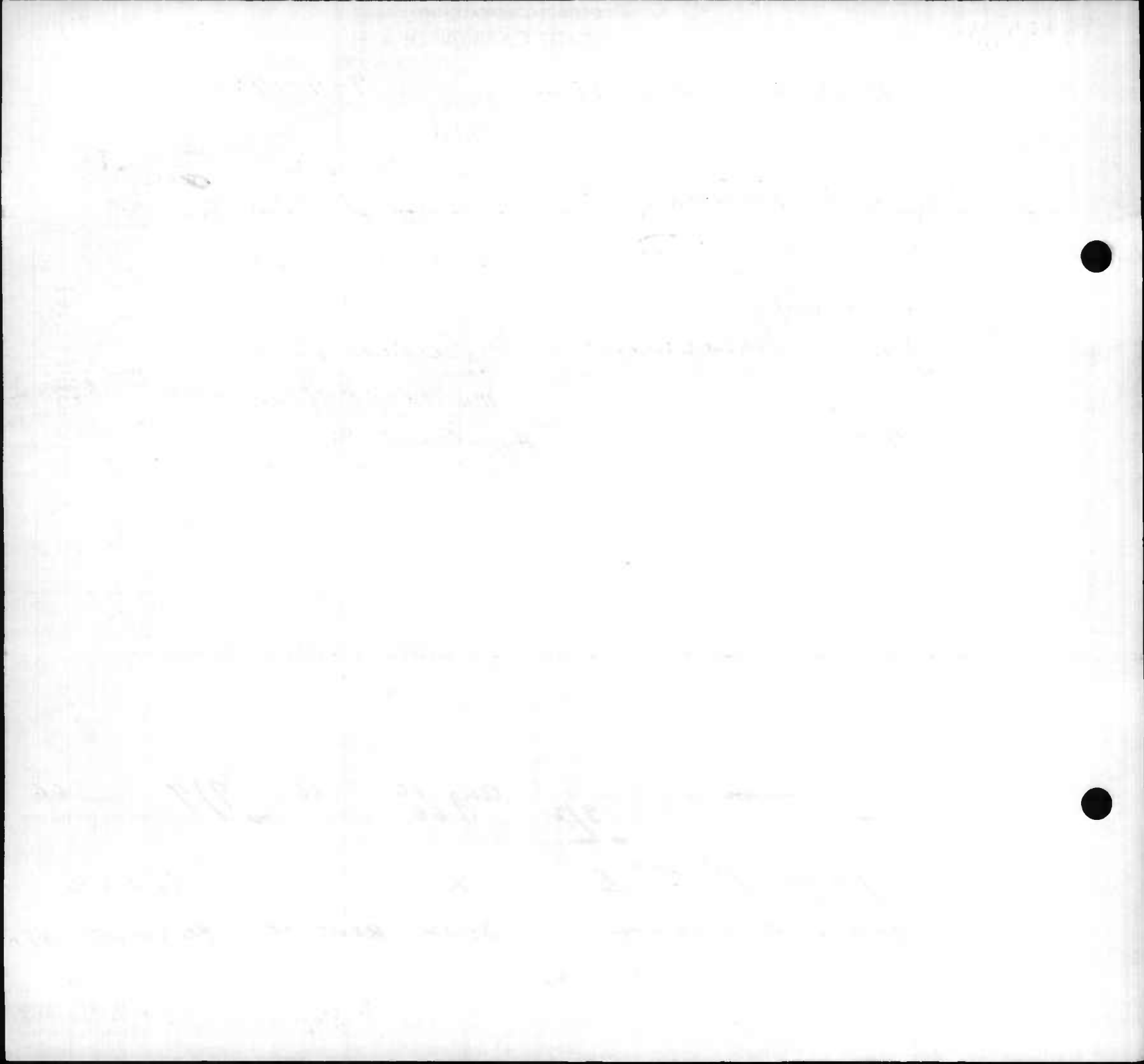
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|---|--|
| BIRTH NO. 66 09130 | | CERTIFICATE OF DEATH | | 66 09130 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) AUDRIA CLOCKER | | | |
| 2. DATE AND HOUR OF DEATH 9-8-66 6:27 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) 2302 E. BIDDLE ST. | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) m | | | |
| 8. DATE OF BIRTH 12-23-15 9. AGE (In years last birthday) 50 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME ALONZO STEINERT | | 14. MOTHER'S MAIDEN NAME CATHARINE. HOFFMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 317-38-1709 | | 17. INFORMANT Ed. Clocker ADDRESS 4525 Forest View Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SHOCK | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 9 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION | | (B) DUE TO | | 14 hrs. | |
| STROKE | | (C) DUE TO | | 15 hrs. | |
| ASCVD, HCVD, DIABETES | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 8-30 19 66 to 9-8 19 66 , that (1) (we) last saw the deceased alive on 9-7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jay Martin Banash | | | | 23B. DATE SIGNED 9-8-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | |
| 25C. FUNERAL DIRECTOR Thelma A. Hoffmann | | ADDRESS 3218 Hudson St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

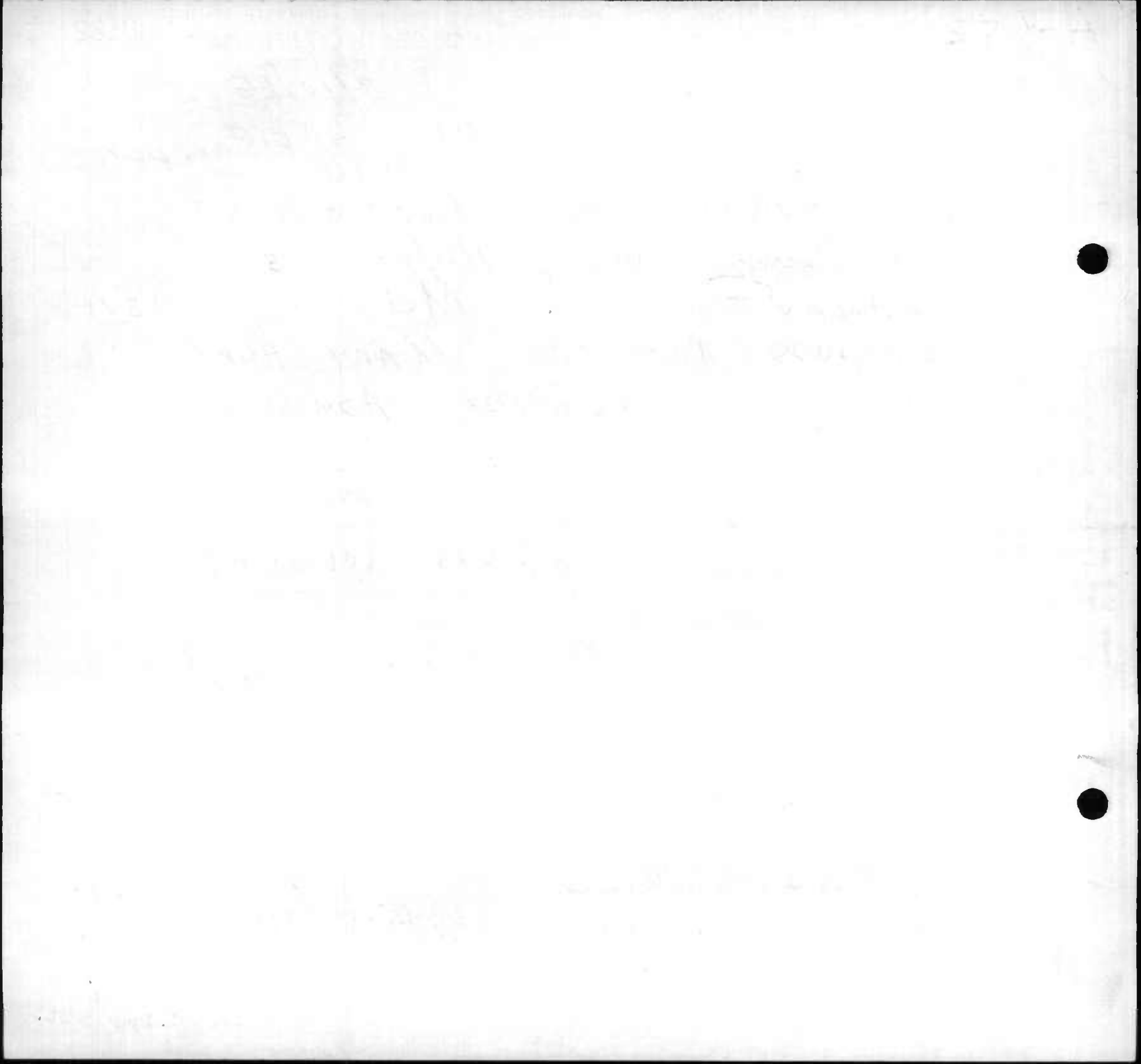
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|--|---------------------|---|--|---|--|
| BIRTH NO. 66 09131 | | CITY OF BALTIMORE HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09131 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MINNIE BOBLITZ | | 2. DATE AND HOUR OF DEATH 9-9-1966 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-10 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 612 N. Potomac St. | | D. STREET ADDRESS (If rural, give location) 324 S. Clinton St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) | | 8. DATE OF BIRTH 9-14-1887 | 9. AGE (In years last birthday) 78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John Smearman | | 14. MOTHER'S MAIDEN NAME Louise Kramer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Marie Hoffman | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X I Hypotensive Cardio-Vascular disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| (B) DUE TO | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Aug. 10 1966 to 9/9 1966, that (I) (we) last saw the deceased alive on 9/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph R. Liberto M.D. | | | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO | | 23D. ADDRESS 3508 BAIT ST. BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel | |
| 24D. LOCATION md. Balto! | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Fickel | | 25C. FUNERAL DIRECTOR Thelma D. Hoffmann | |
| | | ADDRESS 3218 Hudson St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

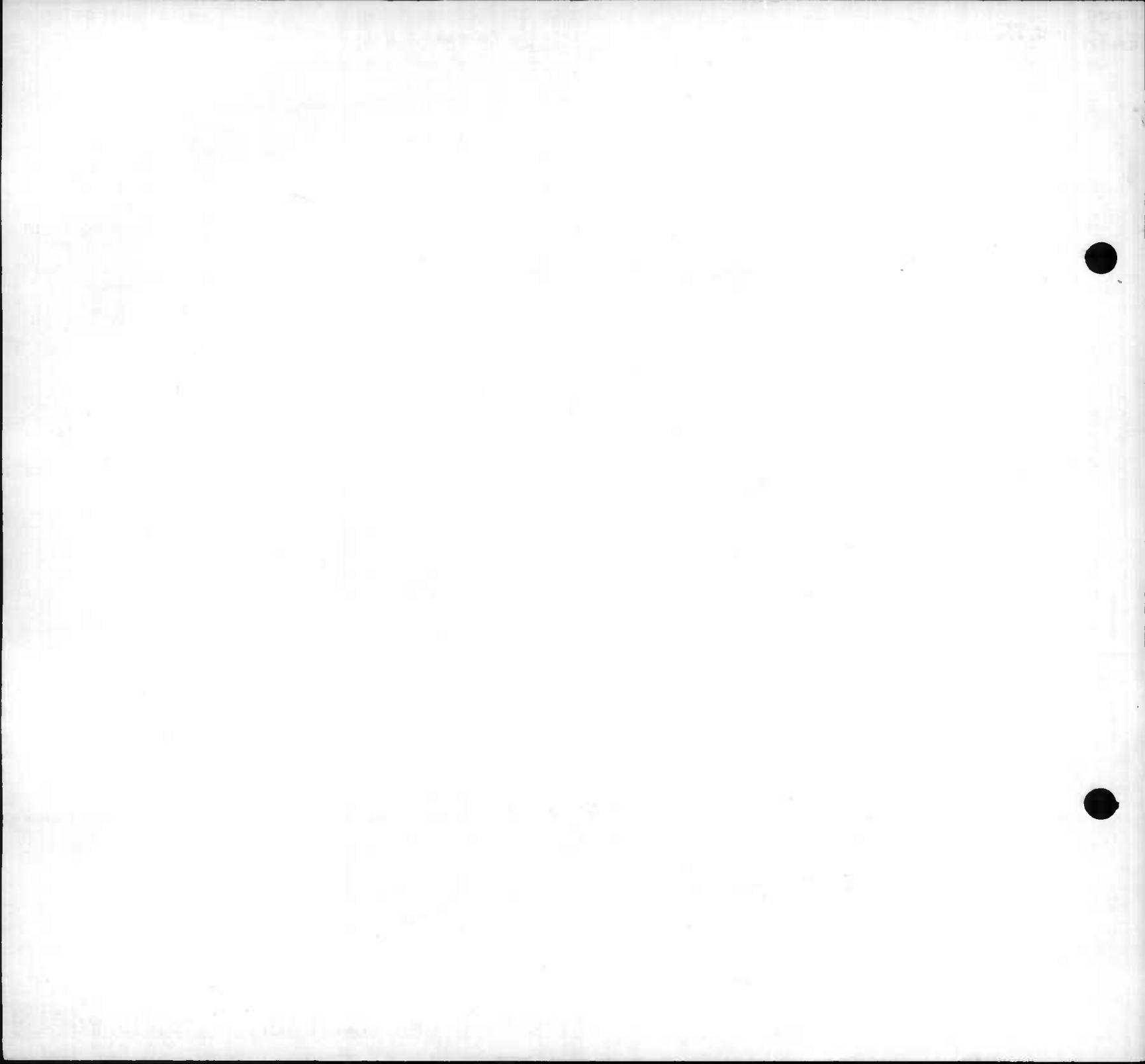
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| 66 09132 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09132 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| IRVING ARMIGER | | 9/10/66 | | 13 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| USPHS HOSP. BALTIMORE | | Md. BALTO | | | |
| 28 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTO | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1307 LIGHT ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| M | Cauc | DIV | 9/30/07 | 58 | SEAMAN |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| | | Arundel Corp. | Md. | USA | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| GUSTAVUS ARMIGER | | | MARY HORNER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| no none | | | 216-09-9729 | | |
| 17. INFORMANT | | | ADDRESS | | |
| ADMISSION | | | SHORT | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) | | | YRS | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/5 1966 to 9/10 1966, that (I) (we) last saw the deceased alive on 9/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Michael E. Pelczar | | | | 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| MICHAEL E. PELCZAR | | USPHS HOSP BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/13/66 | | Cedar Hill Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 12 1966 | | Robert E. Talley | | KRAUSE FUNERAL HOME | |
| | | | | ADDRESS | |
| | | | | 1216 S. Charles St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|------------------|---|---------------------------------|
| 66 09133 | | CERTIFICATE OF DEATH | | 66 09133 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Patricia Scott | | 9-8-66 6:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| George Washington Nursing Home | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore 15-02 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1802 Pressman Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | N | 5 | 4-24-1907 | 59 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Unemployed | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Louis Scott | | Charlotte Scott | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes | | 212-69-0136 | | Chart # 803 607 Penn. Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| 331 XI | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | B. DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | C. DUE TO | | | |
| II | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 10th | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/29/66 to 9/8/66, that (I) (we) last saw the deceased alive on 9/6/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| E.E. Holt | | | | 9/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| E.E. Holt | | | | 3715 Liberty Hgts. Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-12-66 | | Baltimore National | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 12 1966 | | Robert E. Farkas | | Morton E. Dyett Fill 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|------------------------------------|---|---|
| BIRTH NO. 66 09134 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09134 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Carrie Smith</i> | | 2. DATE AND HOUR OF DEATH <i>9-8-66 12¹⁵</i> <i>A</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY | | | |
| 90 FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey Street</i> <i>Baltimore, Md. 21223</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>1823 PATTERSON PARK AVE.</i> | |
| 5. SEX <i>Female</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>2/15/07</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | | 11. BIRTHPLACE (State or foreign country) <i>Hampton, VA.</i> | |
| 13. FATHER'S NAME <i>UNKNOWN</i> | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Gilbert T. Ilery</i> ADDRESS <i>2308 RIKENS ST.</i> | |
| 18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CEREBRAL VASCULAR ACCIDENT</i> ANTECEDENT CAUSES <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/24/59</i> 19 to <i>9/8/66</i> 19 that (I) (we) last saw the deceased alive on <i>9/8/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Harris Sewaine, M.D.</i> | | 23B. DATE SIGNED <i>9/9/66</i> | | 23C. PHYSICIAN'S NAME (Type) <i>HARRIS SEWANE</i> M.D. | |
| 23D. ADDRESS <i>930 WHITELOCK ST. BALT</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-10-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1966</i> | | 25B. NAME OF REGISTRAR <i>R. B. E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Montgomery Dyett F.H.</i> ADDRESS <i>1701 Laurens</i> | |

Carroll County, Md.

Marion County, W. Va.

4/12/10

4/12/10

4/12/10

4/12/10

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4/12/10

4/12/10

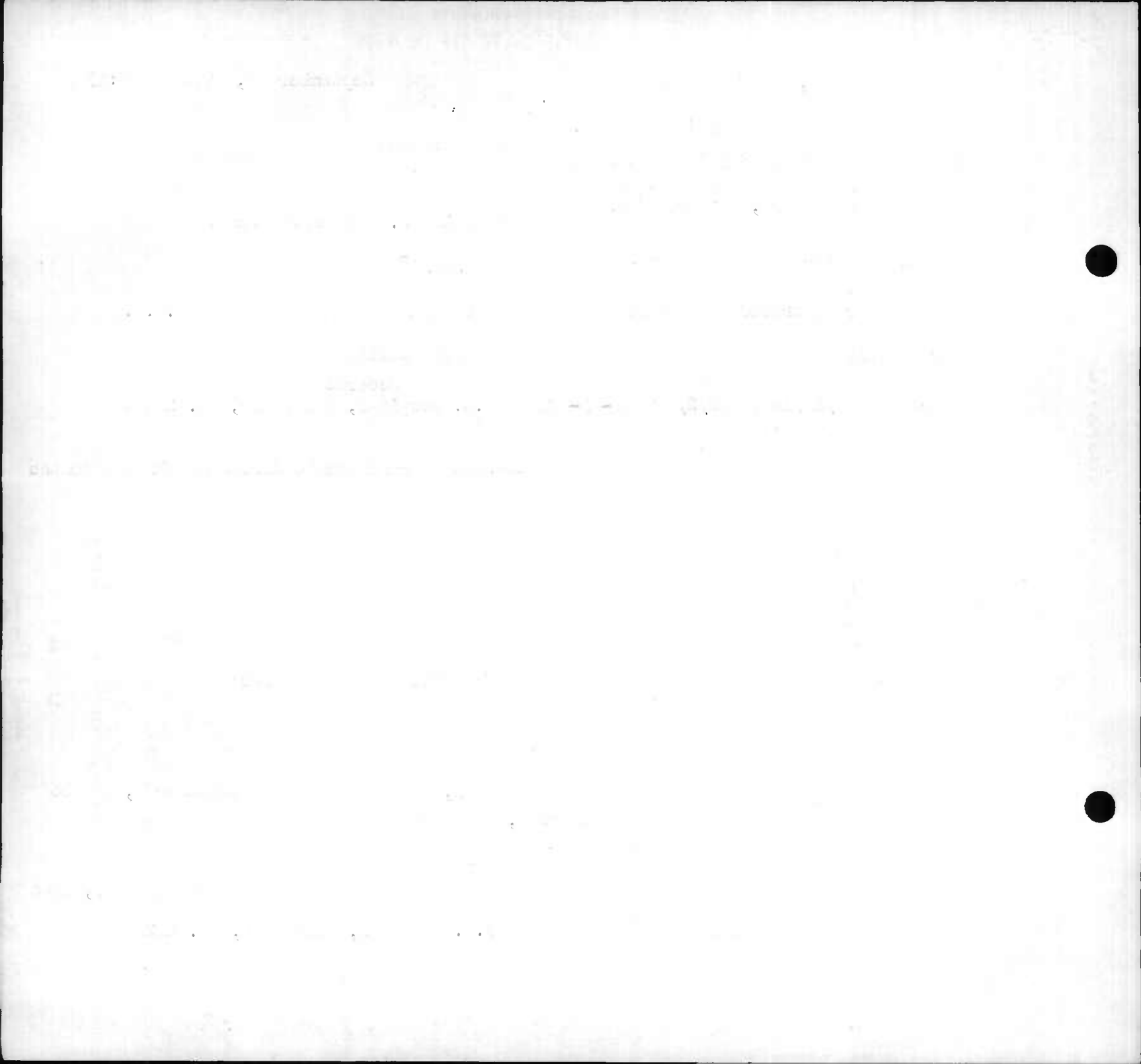
4/12/10

4/12/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

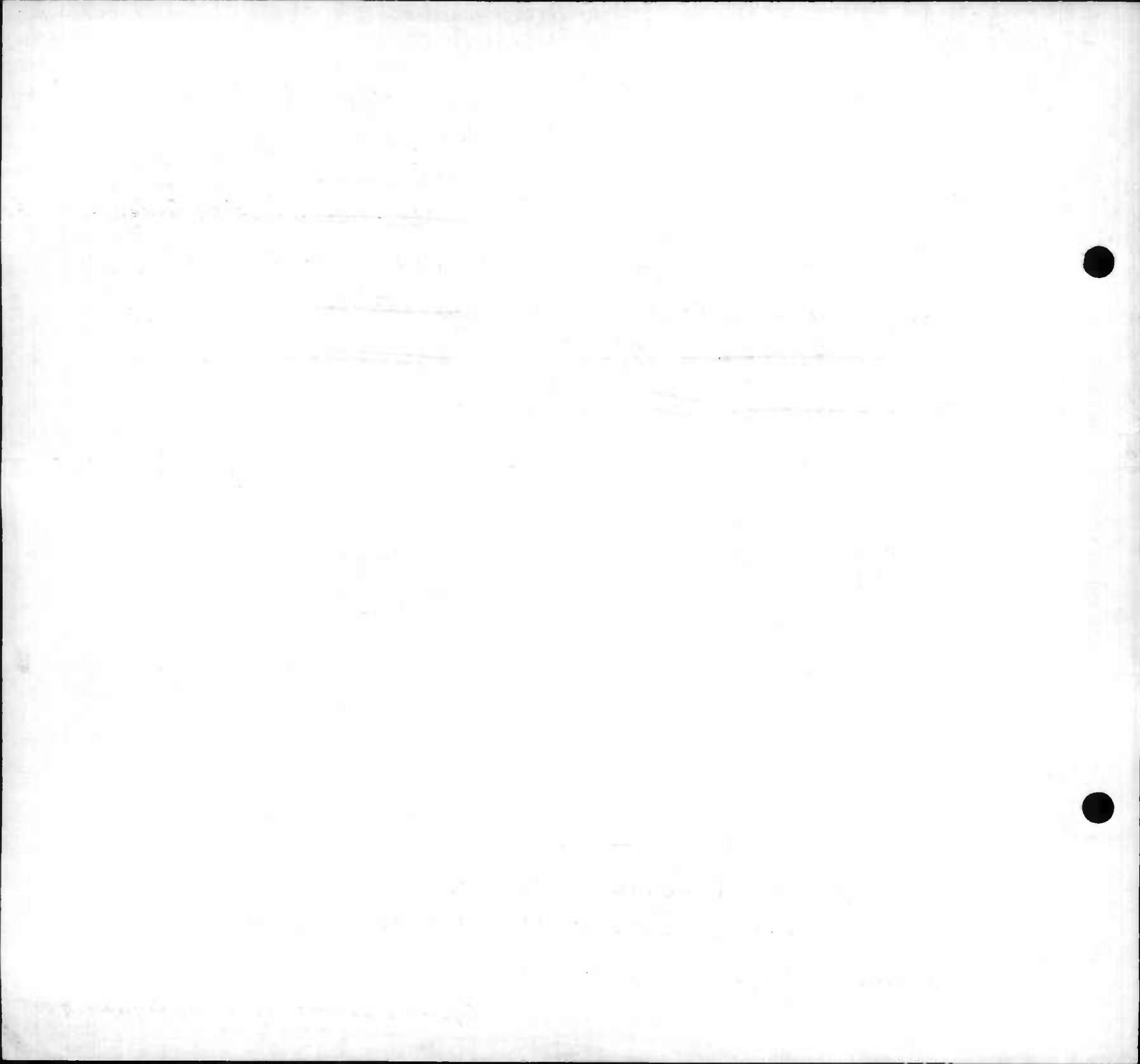
| | | | | | |
|--|---------|--|------------------|--|--|
| 66 09135 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09135 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| COLE, Royal Franklin | | September 8, 1966 | | 5:45 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | | |
| Veterans Administration Hospital | | Maryland | | | |
| 3900 Loch Raven Boulevard | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Baltimore, Maryland 21218 | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1020 W. Lafayette Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days Hours Min. |
| Male | Negro | Widowed | 10/29/97 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Switchboard Operator | | Unknown | | Maryland x | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Frank Cole | | Lydia Smith | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | 6/18/18 to 12/2/18 115-03-1539 | | Records V.A. Hospital, Baltimore, Md. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from June 13, 19 66 to September 8, 19 66, that (X) (we) last saw the deceased alive on September 8, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Thomas Zizic | | | | September 9, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| THOMAS ZIZIC | | V.A. Hospital, Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-12-66 | | Baltimore NAT'L Cem. | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 12 1966 | | Robert E. Taylor | | MORTON & DYETT 1701 LAWRENS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---------------------------------|--|---|
| BIRTH NO. 66 09136 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09136 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Sherer, Joseph</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 10, 1966 11:20 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY | |
| <u>Stonai Hospital of Baltimore</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | <u>Baltimore</u> | |
| | | D. STREET ADDRESS (If rural, give location) | | <u>4721 BERRY AVE. 5107 QUEENS BERRY AVE</u> | |
| 5. SEX <u>M.</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>1/16/18</u> | 9. AGE (In years last birthday) <u>48</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>USAF (Civ.)</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>ANN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT ADDRESS <u>Hospital records</u> | |
| 18. I <u>420.1</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO <u>Acute myocardial infarction</u> | | | |
| ANTECEDENT CAUSES | | (B) DUE TO <u>none</u> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <u>none</u> | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 9</u> 1966 to <u>Sept 10</u> 1966, that (I) <u>we</u> last saw the deceased alive on <u>Sept 10</u> 1966 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>(did not)</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Manuel Levin</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/11/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u> | | 23D. ADDRESS <u>4818 REISTERSTOWN RD BALTO MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/11/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>ROSGALE</u> | |
| 24D. LOCATION (City, town, or county) <u>BALTO. MD</u> | | 24E. LOCATION (State) <u>MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | 25B. NAME OF REGISTRAR <u>Paul E. Farley</u> | | 25C. FUNERAL DIRECTOR <u>SYLON J. LEWIS</u> | |
| 25D. ADDRESS <u>3319 OLYMPIA AVE</u> | | | | | |



1
K-422

66 09137

BALTIMORE CITY HEALTH DEPARTMENT

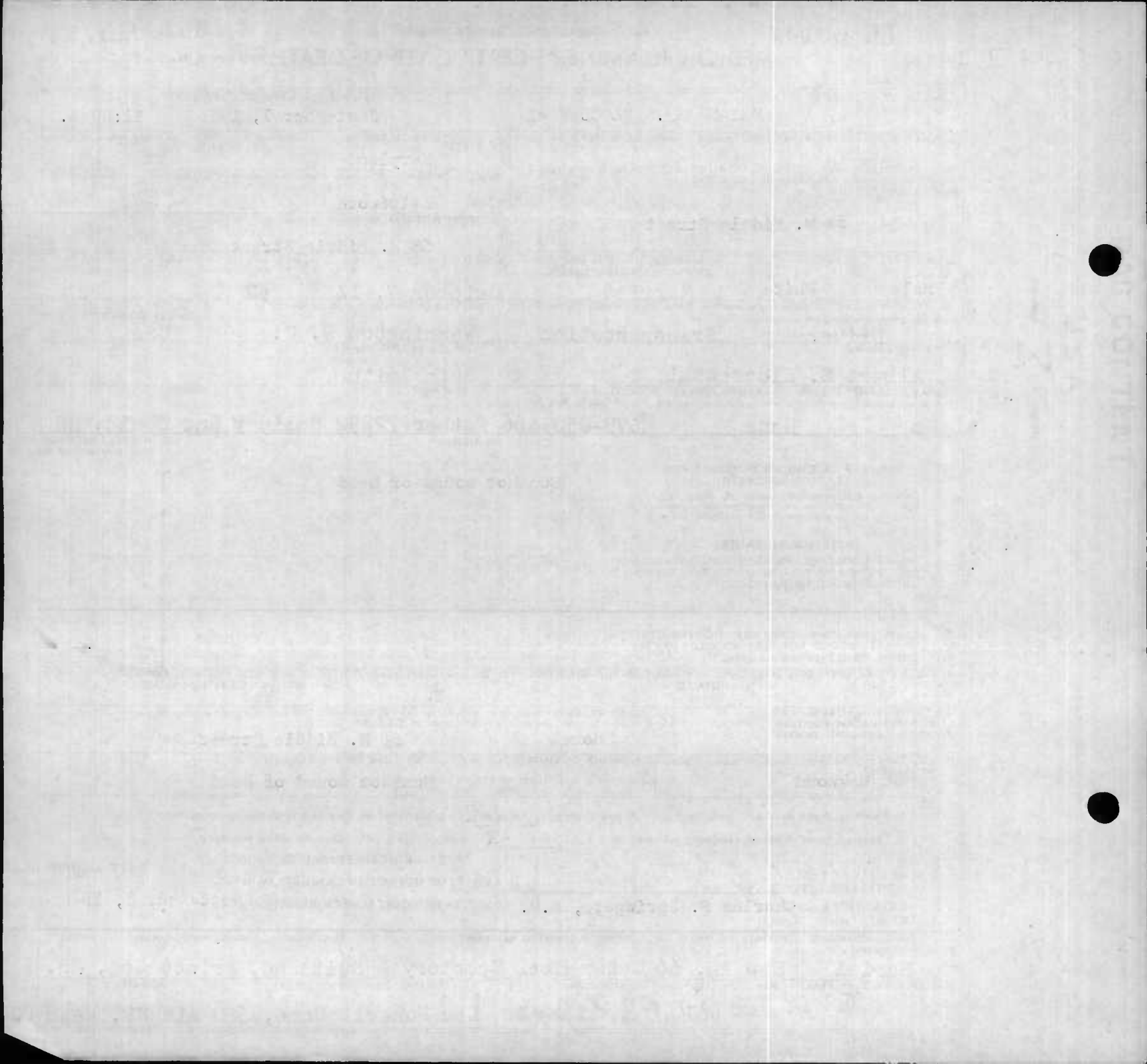
66 09137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

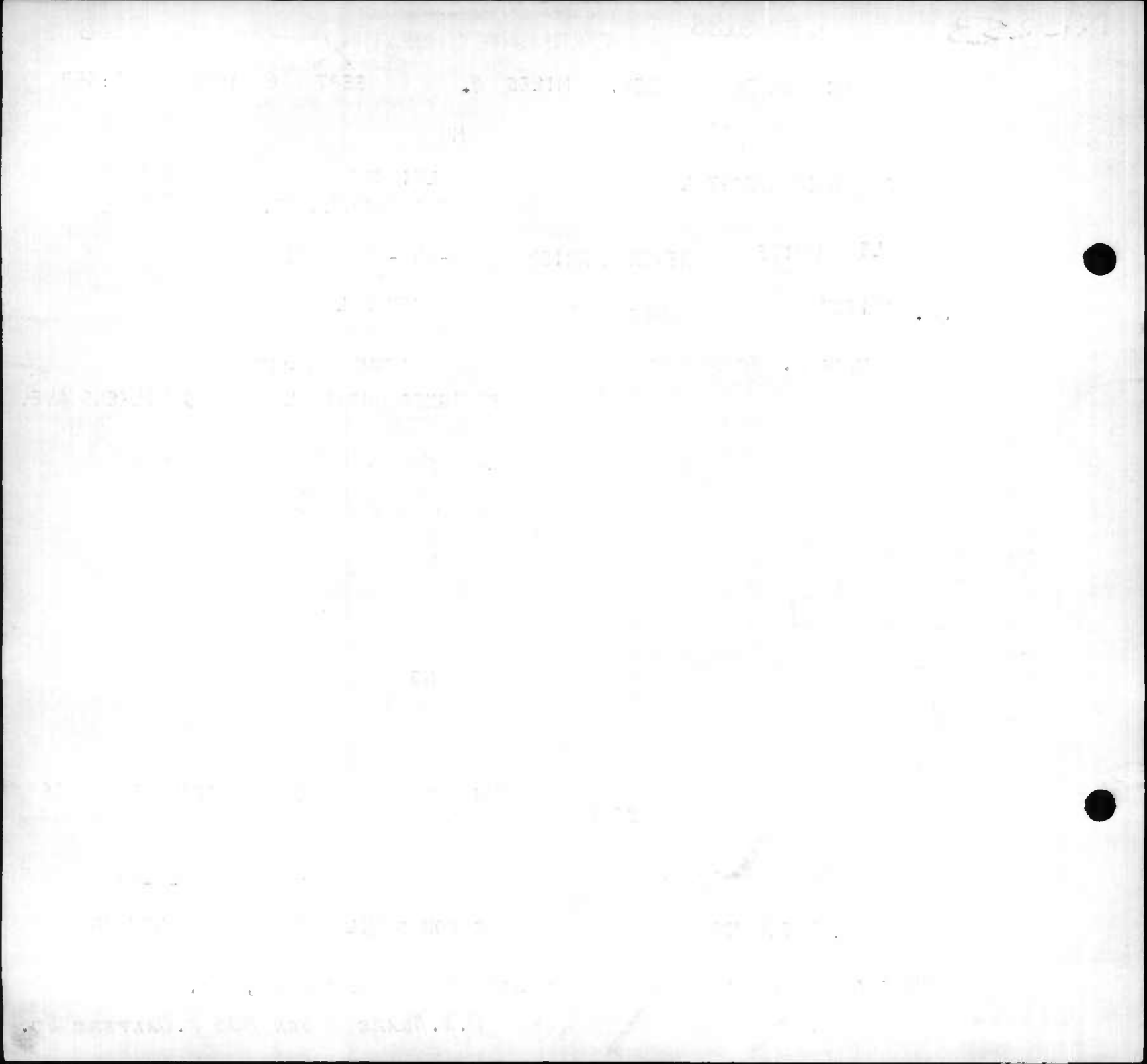
| | | | | | | | |
|---|-------------------------|---|--|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) ADRIAN M. KLOCZEWSKI | | | | 2. DATE AND HOUR PRONOUNCED DEAD September 7, 1966 11:00 A. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 58 W. Biddle Street | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 58 W. Biddle Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH October 7, 14 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Transportation | | 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Albert M. Kloczewski | | | | 14. MOTHER'S MAIDEN NAME Ruth Smith | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 579-0509566 | | 17. INFORMANT ADDRESS Father 12832 Holiday Ln, Bowie, Md | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 58 W. Biddle Street | | | |
| 21D. TIME OF INJURY (APPROX.) Unknown | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Gunshot wound of head | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 8, 1966 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Sep 10, 66 | | 23C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | | 23D. LOCATION (City, town, or county) (State) Suitland, Prince Geo, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 24B. NAME OF REGISTRAR Robert E. Folsom | | 24C. FUNERAL DIRECTOR ADDRESS Lee Funeral Home, 300 4th NE, Wash DC | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|--|--|-------------------------------------|--|--|--|
| 66 09138 | | | | | 66 09138 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MC ANDREW REV. MILES M. | | | | | 2. DATE AND HOUR OF DEATH SEPT 6 1966 1:55P | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL | | | | | A. STATE MD | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY BALTO | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1222 TUGWELL DR. | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 8-24 -00 | | 9. AGE (In years last birthday) 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.C. PRIEST | | 10B. KIND OF BUSINESS OR INDUSTRY TEACHER | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME MILES J. MCANDREW | | | | | 14. MOTHER'S MAIDEN NAME ALICE NORTON | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE. | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ante myocardial Infarction | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | |
| | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUG 22 1966 to SEPT 6 1966 , that (I) (we) last saw the deceased alive on SEPT 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) R. MARIN MX | | | | | 23D. ADDRESS CATON & WILKENS AVENUE BALTO MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY or CREMATORY ARCHBALD | | | 24D. LOCATION (City, town, or county) (State) ARCHBALD, PA. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | | 25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST. | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

09139

66 09139

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD W. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1966

11:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1902 E. Fairmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1902 E. Fairmount Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

UNK

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BAR TENDER

10B. KIND OF BUSINESS OR INDUSTRY

SINK WAREHOUSE

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

219-22-7754

17. INFORMANT

ADDRESS

HENRY WOODBY 1703 E BALTIMORE ST

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 2, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

SEPT 9 1966

23C. NAME of CEMETERY or CREMATORY

ST PAUL'S CEMETERY

23D. LOCATION

(City, town, or county)

(State)

5600 CARDIFF AVE

MD

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

24B. NAME OF REGISTRAR

R. B. E. F. F. F.

24C. FUNERAL DIRECTOR

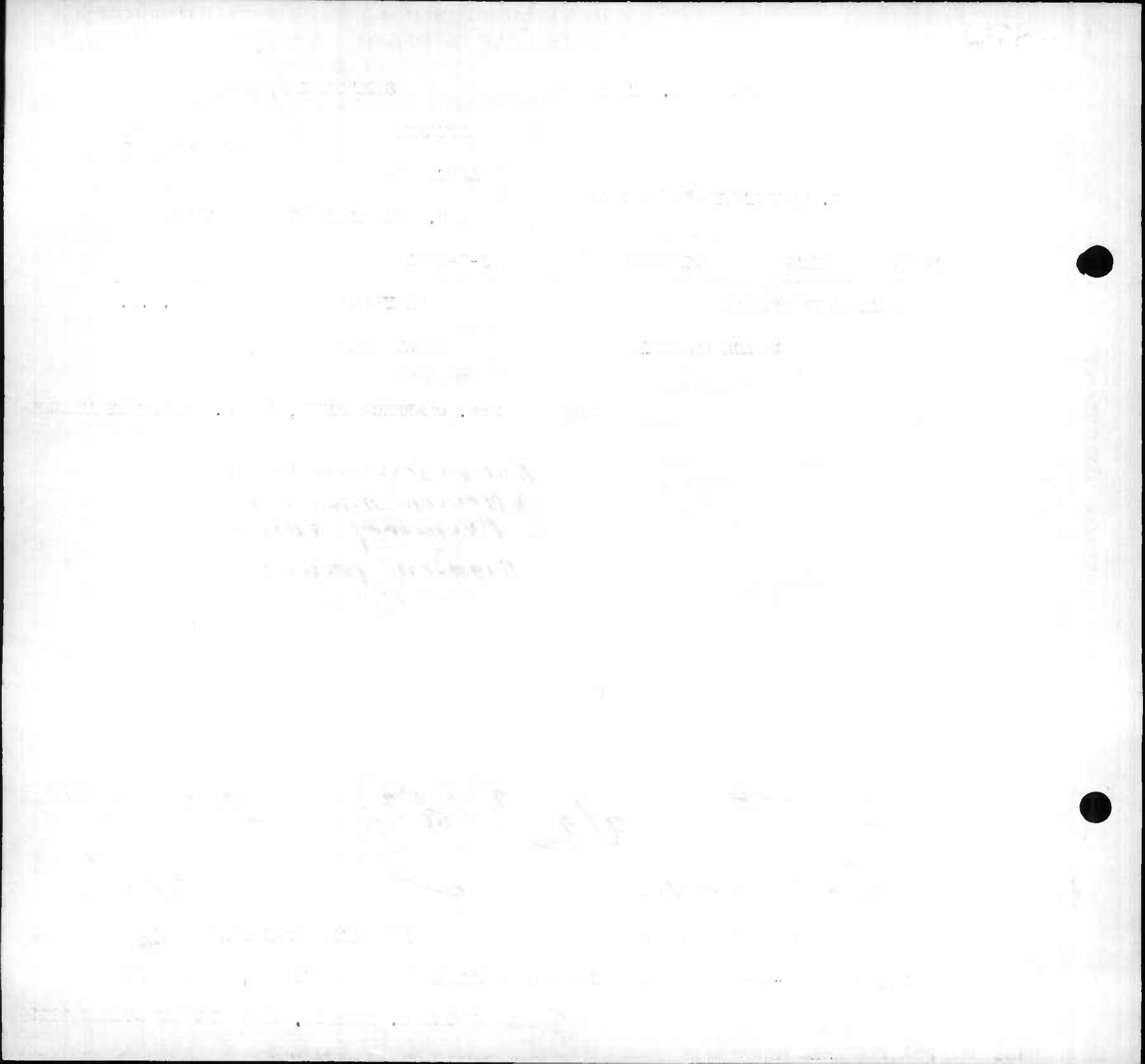
DIPPEL BROS INC 1800 E LOMBARD ST

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09140 | |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 09140 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELEANOR C. STAMM | | 2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 106 S. MONASTERY AVENUE 21229 | | A. STATE MARYLAND B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 106 S. MONASTERY AVENUE 21229 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-7-1882 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME GEORGE ELSE ROAD | | 14. MOTHER'S MAIDEN NAME NANCY WELSH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT MRS. CLARENCE STAMM, 106 S. MONASTERY AVENUE | |
| 18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE & PULMONARY EDEMA (B) PULMONARY EDEMA (C) DIABETES MELLITUS | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 7/1/52 19 to 9/9 1966, that (I) (we) lost saw the deceased alive on 7/9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE John H. Shaw | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN SHAW | | M.D. | | 23D. ADDRESS 5800 EDMONDSON AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------|--|-----------------------------|---|---|
| BIRTH NO. 66 09141 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09141 | |
| M.E. CASE NO. | | J. HOWARD HACKMAN | | 2. DATE AND HOUR OF DEATH 9/8/66 5:45pm P.M. | |
| 1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXX XXXXXXXXXX H Hackman | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 714 W. HAMBURG ST. #21230 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-20-83 | 9. AGE (In years last birthday) 83 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRINDER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME HENRY HACKMAN | | 14. MOTHER'S MAIDEN NAME MARY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. EDWARD ENGELSKIRCH, 209 FOURTH AVE RECORDS: BCH 4940 EASTERN AVENUE #21224 | |
| 18. 609 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cardiorespiratory failure - DUE TO (B) Gram negative septicemia - DUE TO (C) G.U. infection and instrumentation - Chronic - | | INTERVAL BETWEEN ONSET AND DEATH = 2 hr home = 24 hrs Chronic - | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD = Atrial fibrillation - | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14/66 19 to 9/8/66 19, that (I) (we) last saw the deceased alive on 9/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Terry Ersel Gagon M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) Terry Ersel Gagon M.D. | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 24B. DATE 9-10-66 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Sullivan | | 25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229 | |

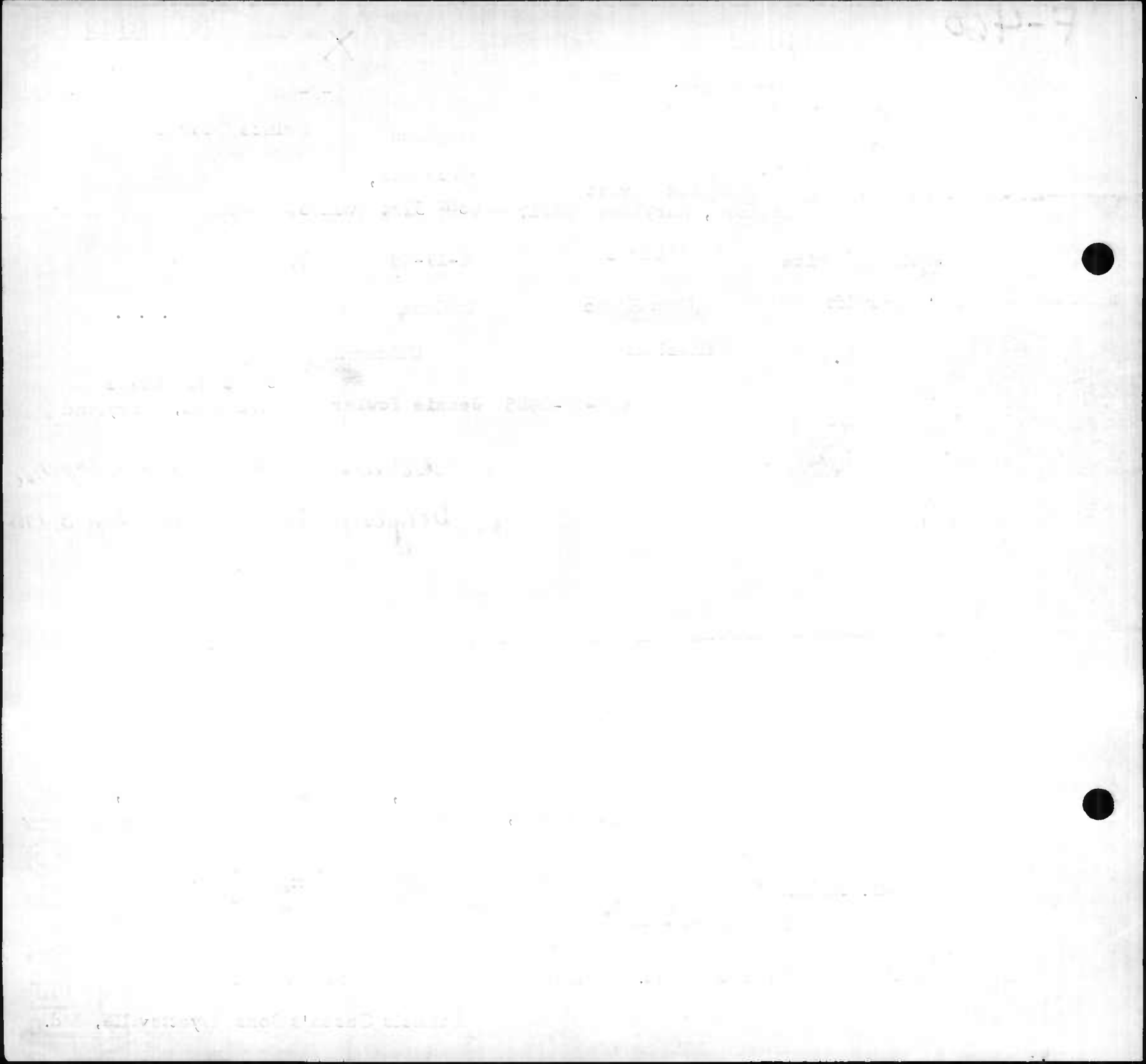
TO RETURN

the right of the
author to the
work of the

FUNERAL DIRECTOR: IMPORTANT

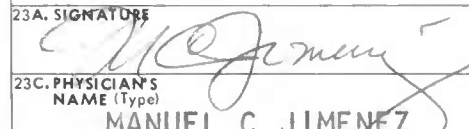
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09142 | |
|---|----------------------|--|---------------------------------|--|---|
| BIRTH NO. 66 09142 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ETHEL M. FOWLER | | 2. DATE AND HOUR OF DEATH 9-3-66 9:30pm. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Prince George C. CITY OR TOWN (If outside city limits, write RURAL and give township) Riverdale, 66-00 D. STREET ADDRESS (If rural, give location) 6309 51st Avenue Long Home | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-11-89 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Indiana | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME (Unk.) Willheight | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 424-07-0985 | | 17. INFORMANT Jessie Fowler ADDRESS 6309 51st Avenue Riverdale, Maryland | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO ① Cardiac arrest of the heart from Aug 31/66 (B) DUE TO ② Dehydration To Sept 3, 1966 (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 31, 1966 to September 3, 1966 , that (I) (we) last saw the deceased alive on September 3, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Amini | | | | 23B. DATE SIGNED 9/3/66 | |
| 23C. PHYSICIAN'S NAME (Type) Amini | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/8/66 | | 24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln | |
| 24D. LOCATION (City, town, or county) Colmar Manor | | (State) Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Francis Gasch's Sons | | 25C. FUNERAL DIRECTOR ADDRESS Hyattsville, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|--|--|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09143 | | | | |
| BIRTH NO. 66 09143 | | | | | 2. DATE AND HOUR OF DEATH 9 9 66 9_15A.M. | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) RUTH N MILLER | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK 52-00 D. STREET ADDRESS (If rural, give location) RT 2, BOX 284 | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12 25 01 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER | | | 10B. KIND OF BUSINESS OR INDUSTRY TRANSIT | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Jess Beck | | | | | 14. MOTHER'S MAIDEN NAME ANNA MICHAEL GOSNER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST AGNES HOSP RECORDS | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Arteriosclerosis DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 8 15 19 66 to 9 9 19 66, that (X) (we) last saw the deceased alive on 9 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 9 9 66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL C JIMENEZ | | | | | 23D. ADDRESS M.D. ST AGNES HOSP, WILKENS & CATON | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem | | 24D. LOCATION BALTO 29 MD (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Ruth E. Talbot | | | 25C. FUNERAL DIRECTOR John J. Brown + Son Inc. | | | ADDRESS 23 Mt. 901 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09144 | |
|--|---------------------|---|---|--|---|
| 66 09144 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>HAMILTON W Hall Jr</u> | | 2. DATE AND HOUR OF DEATH <u>Sept 5, 1966</u> <u>8:30 P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balto</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Parkville</u> <u>53-00</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>2404 OVERLAND AVE</u> | | D. STREET ADDRESS (If rural, give location) <u>9510 ROUNDTREE DRIVE</u> | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED <u>MARRIED</u> | 8. DATE OF BIRTH <u>FEB 19, 1931</u> | 9. AGE (In years last birthday) <u>35</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSTALLER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>CRIP TELEPHONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>HAMILTON W. Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>Ethel McCloud</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>NORFOLK NAVAL</u> | | 16. SOCIAL SECURITY NO. <u>214-28-3005</u> | | 17. INFORMANT <u>Family Records</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>356.11</u> | | CAUSE OF DEATH (A) <u>Brancher Pneumonia</u> DUE TO (B) <u>Amphotrophic Intestinal Infection</u> DUE TO (C) <u>7 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>9-5-66</u> that (I) (we) lost saw the deceased alive on <u>9-5-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>C. W. Penke</u> | | | | 23B. DATE SIGNED <u>9-7-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CLARENCE PENKE</u> | | 23D. ADDRESS <u>4508 NORTON RD</u> | | | |
| 24A. BURIAL CREATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-8-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BALTO NATIONAL CEM</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>R. E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>C. F. EVANS</u> | | | |
| 25D. ADDRESS <u>8802 NORTON RD</u> | | | | | |

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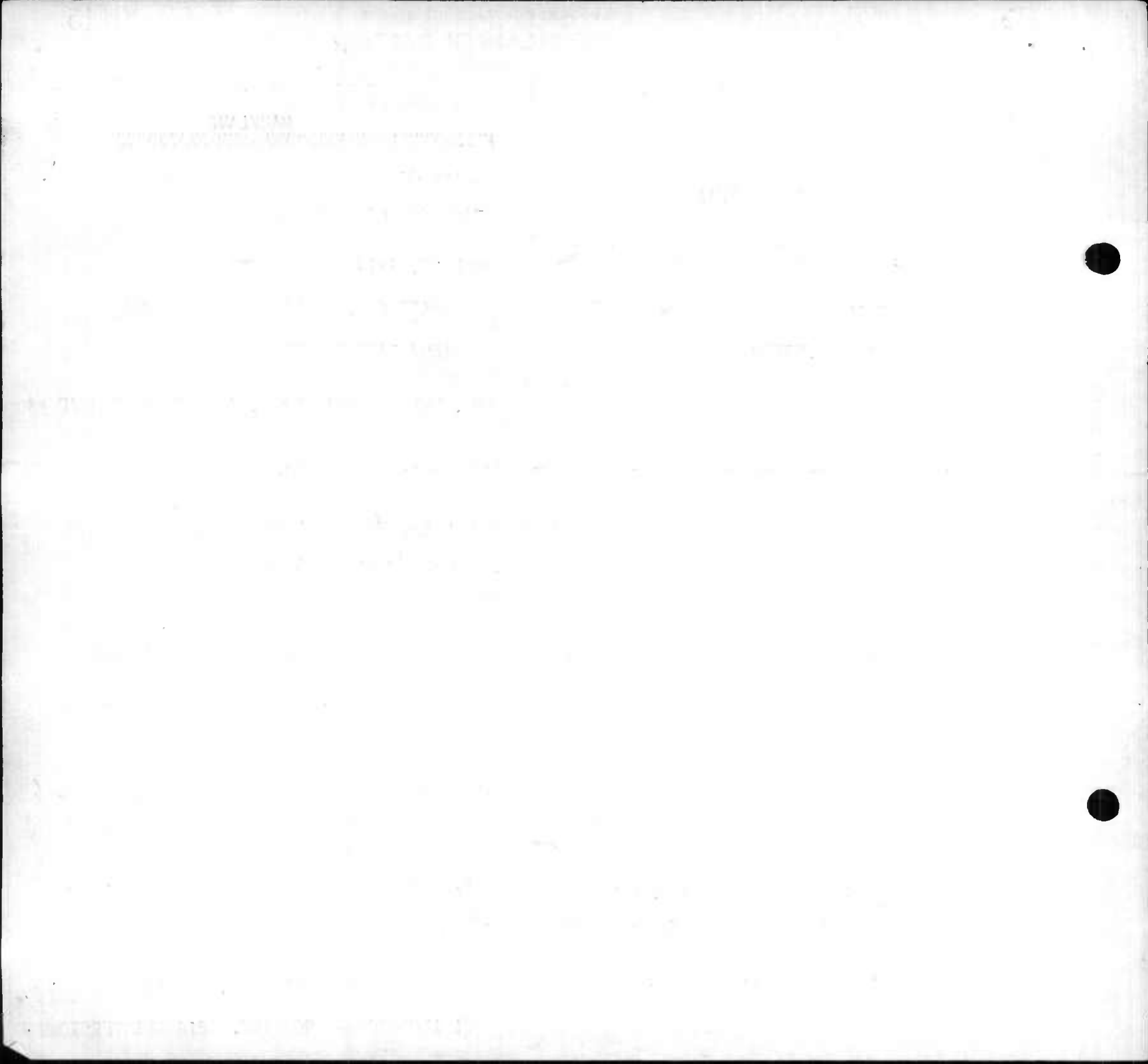
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------|---|-----------------------------------|
| 66 09145 | | 66 09145 | |
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Goldstein Bernard | | 2. DATE AND HOUR OF DEATH 9-9-66 11:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL | | A. STATE MARYLAND B. COUNTY BALTO | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN BALTIMORE (If outside city limits, write RURAL and give township) 53-00 | |
| D. STREET ADDRESS 7006 CONCORD ROAD #8 | | (If rural, give location) | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH JUNE 27, 1914 |
| 9. AGE (In years last birthday) 52 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL | | 10B. KIND OF BUSINESS OR INDUSTRY MERCHANT | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME HYMAN GOLDSTEIN | | 14. MOTHER'S MAIDEN NAME LENA ZARENBOVITZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. THERESA GOLDSTEIN, 7006 CONCORD ROAD #8 | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH (A) Coronary Occlusion 5 hrs (B) Atherosclerosis of coronary 5 yrs (C) artery disease | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-7-1966 to 9-9-1966, that (I) (we) last saw the deceased alive on 9-9-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Irvin Sauber | | 23B. DATE SIGNED 9-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) IRVIN SAUBER | | 23D. ADDRESS 6905 Park Hgts Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/11/66 | |
| 24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW | | 24D. LOCATION REISTERSTOWN, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Sauber | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. | | 25D. ADDRESS 6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09146 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09146 | |
|--|---------------------|---|---|--|--|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MRS. VALENSE BOSSERT | | | | 2. DATE AND HOUR OF DEATH 9-6-66 19¹⁵ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL | | | | A. STATE MARYLAND B. COUNTY 20-08 | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 29 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 98-S. COLLINS AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1901 5/21/1901 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME THOMAS KELLEY | | | | 14. MOTHER'S MAIDEN NAME MARY BRENNAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART | | |
| | | | | | ADDRESS 98 S. Collins Ave. Dorothy Bossert | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION Sept. 3, 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (†) (this hospital) attended the deceased from Aug. 31 1966 to Sept. 6 1966 , that (I) (we) last saw the deceased alive on Sept. 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (†) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Adolfo G. de Perio | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 6, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) ADOLFO G. DE PERIO | | | | 23D. ADDRESS BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 9, 1966 | | 24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | ADDRESS 3512 Frederick Ave. Balto. Md. | |

MARYLAND
BALTIMORE

NEW ZEALAND HOSPITAL 18-19-1914
F W WIDOWED 21/11/14

MARYLAND

MARY BAKER
GART

Thomas Kelly

Good fortune

Right to the same as before

Left 12/11/14

Adopted 12/11/14
Left 12/11/14

BIRTH NO. 62-23095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THOMAS

WILLIAMS, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1966

2:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

125 Colvin Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-2-62

9. AGE (In years
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS WILLIAMS

14. MOTHER'S MAIDEN NAME

DOROTHY Redfern

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

DOROTHY EVANS 125 COLVIN ST

18.

E902.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

125 Colvin Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 7 '66 P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell out of 10th floor apt. window.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/8/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-10-66

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION (City, town, or county) (State)

A.A. COUNTY Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

JOSEPH KNIGHT 1639 N BROADWAY

ADDRESS

W/ALBURY PROJECT

RECEIVED

1954
1-2

1
F-516

| 66 09148 | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 09148 | |
|---|--------------------|---|-----------------------------|---|---|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | Doffies Funderdurd | | 2. DATE AND HOUR PRONOUNCED DEAD 9/9/66 12:20 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| 1704 Poplar Grove St. | | D. STREET ADDRESS (If rural, give location) 1704 Poplar Grove St. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 9-17-14 | 9. AGE (In years, last birthday) 52 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOLDER HELPER | | 10B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT | | 11. BIRTHPLACE (State or foreign country) N C | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JAMES FunderBUCK | | | |
| 14. MOTHER'S MAIDEN NAME WILMA RICHARDSON | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.2 4-22-44 10-30-45 | | | |
| 16. SOCIAL SECURITY NO. 249-05-7823 | | 17. INFORMANT ADDRESS MRS. BLACKMAN 1712 E. LANVALE ST. | | | |
| 18. CAUSE OF DEATH 451X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Rupture of aorta due to idiopathic cystic medionecrosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/9/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 9-13-66 | | 23C. NAME OF CEMETERY or CREMATORY GARDEN-ET HOPE INC. FINKS BURG Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 24B. NAME OF REGISTRAR Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BroadWAY | |

VALLEY FOLIO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|--|--|---|
| 66 09149 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09149 | |
| BIRTH NO. <i>Touzon, Md.</i> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>AMY MARICLE</i> | | 2. DATE AND HOUR OF DEATH <i>7-SEPT-1966 5⁰⁰ P M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Balto</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i> <i>BALTIMORE Md. 21201</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 21234 53-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>2415 WOODCROFT ROAD</i> | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>CAUCASIAN</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i> | 8. DATE OF BIRTH <i>13-AUG-1966</i> | 9. AGE (In years last birthday) <i>0 25</i> | If Under 1 Yr. Months: Days: Hours: Min. <i>0 25</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | 13. FATHER'S NAME <i>DAVID MARICLE</i> | | 14. MOTHER'S MAIDEN NAME <i>SUSAN MAY JENTRY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>PARENTS KENNETH R. KOSKINEN MD</i> | |
| 18. <i>7540 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Transpiration of the Great Vessels with ASD, MDD & pulm. Scarpin</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>NONE</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> 19 <i>66</i> to <i>9/7</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/7</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Chung K. Bae</i> M.D. | | | | 23B. DATE SIGNED <i>9/7/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. <i>UNIVERSITY HOSPITAL BALTO. MD 21201</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-9-66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>MORELAND MEM. PARK</i> | |
| 24D. LOCATION <i>BALTO MD</i> | | 24E. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 24F. FUNERAL DIRECTOR <i>C. F. EMMETT & SON 8802 HARTFORD RD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1966</i> | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

1862
Jan 1st
to
Feb 1st

to 1st

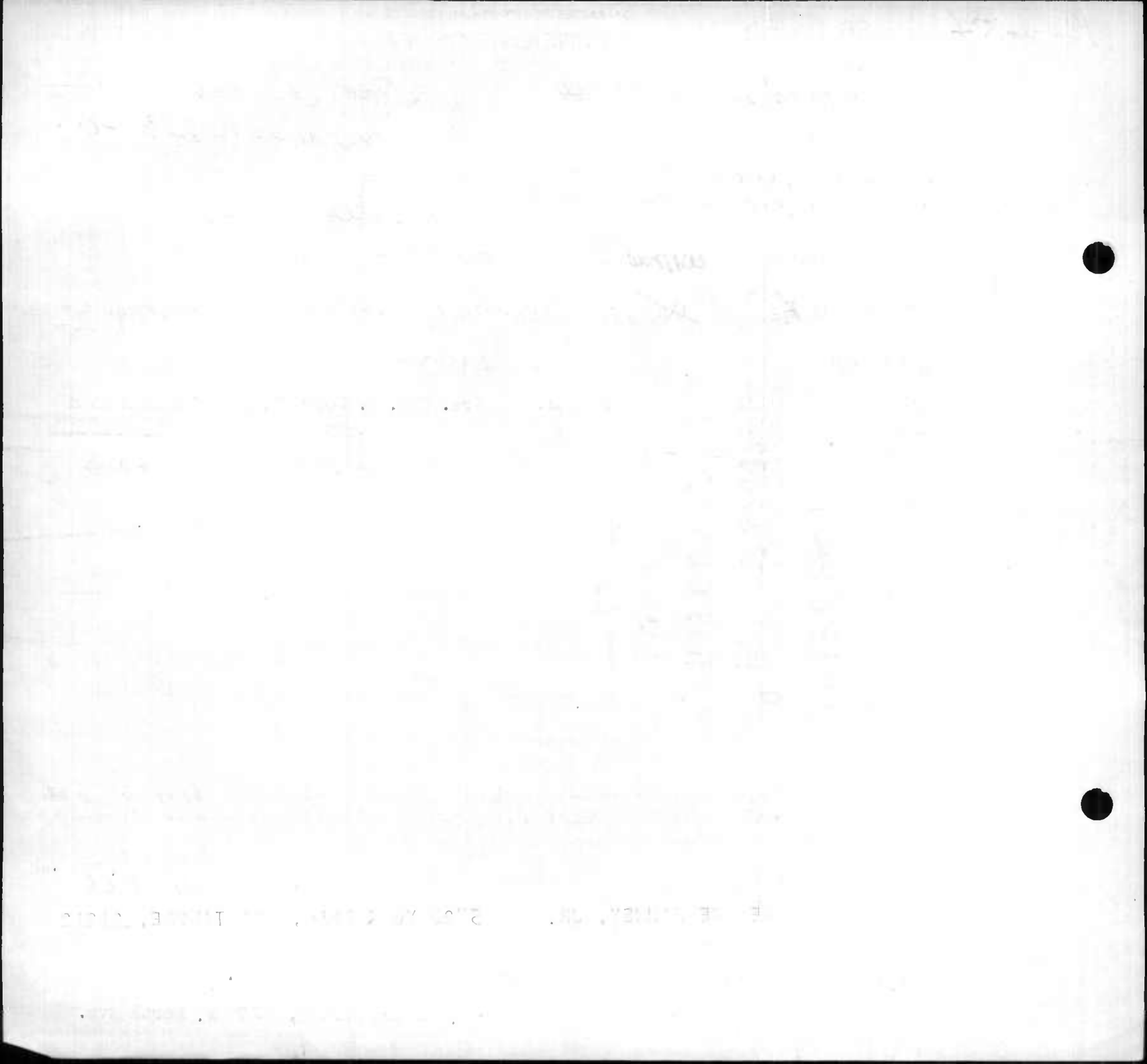
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to 1st

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

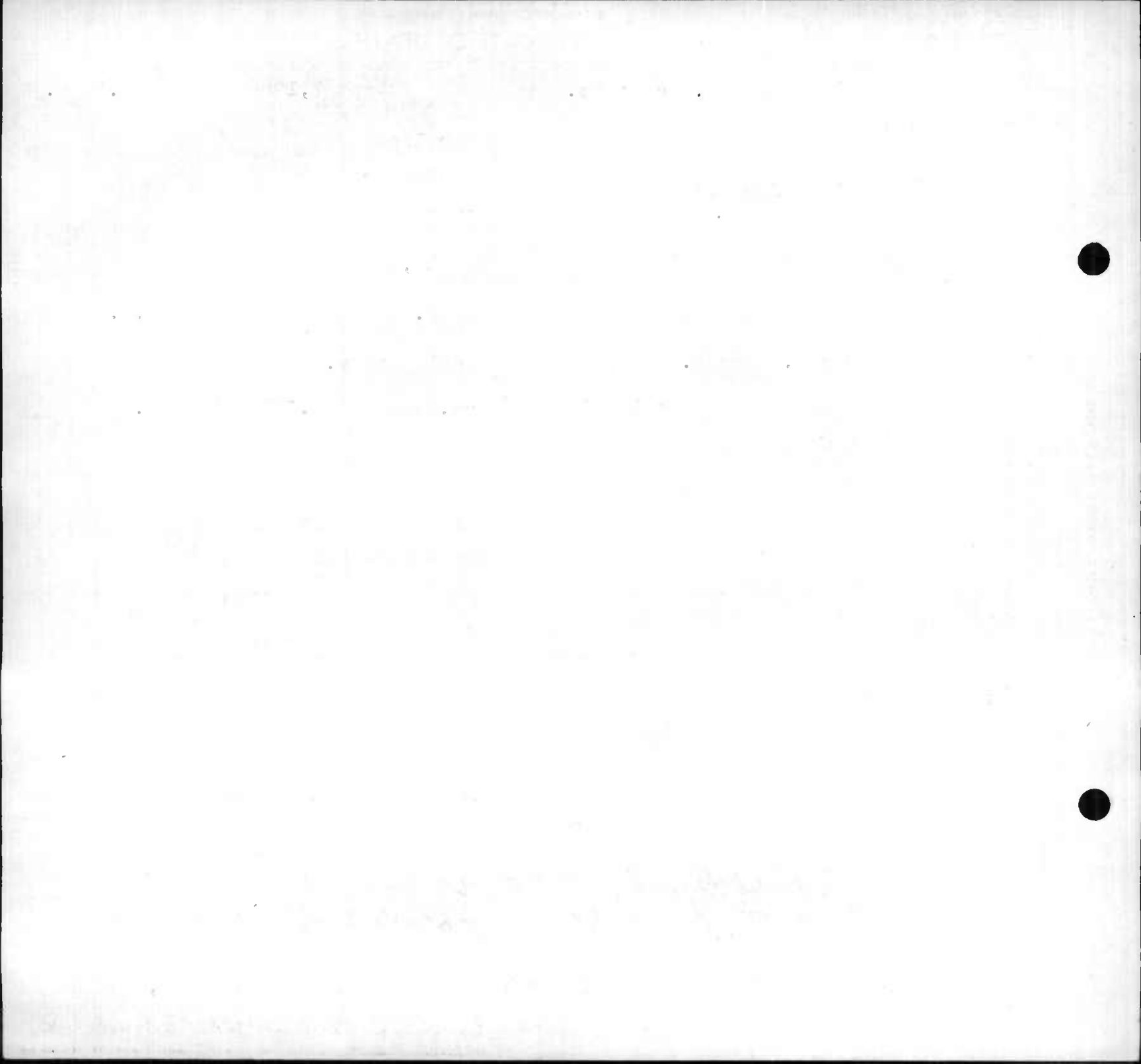
| | | | | | |
|--|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 09150 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09150 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CRYSTAL MAUDE, ARNOLD | | | |
| 2. DATE AND HOUR OF DEATH SEPT 6, 1966 9:30 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL | | A. STATE MD. B. COUNTY BALTIMORE | | | |
| (If not in hospital or institution, give street address or location) 33RD AND CALVERT ST, BALTIMORE, MD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 5107 OAKLAWN ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 08/18/75 | 9. AGE (In years last birthday) 91 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) GREAT BRITAIN | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN CITIZEN | | 13. FATHER'S NAME UNKNOWN | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mrs. Geo. W. Gorrell, 5107 Oaklawn Road | | | |
| 18. 585X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute CHOLECYSTITIS | | (A) DUE TO | | 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT 5, 1966 to SEPT 6, 1966 , that (I) (we) last saw the deceased alive on SEPT 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George Finney, Jr. | | | | 23B. DATE SIGNED SEPT 6 '66 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE FINNEY, JR. | | | | 23D. ADDRESS 5820 YORK ROAD, BALTIMORE, 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/9/66 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. Sullivan | | 25C. FUNERAL DIRECTOR G. Howard Strong, 3207 W. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

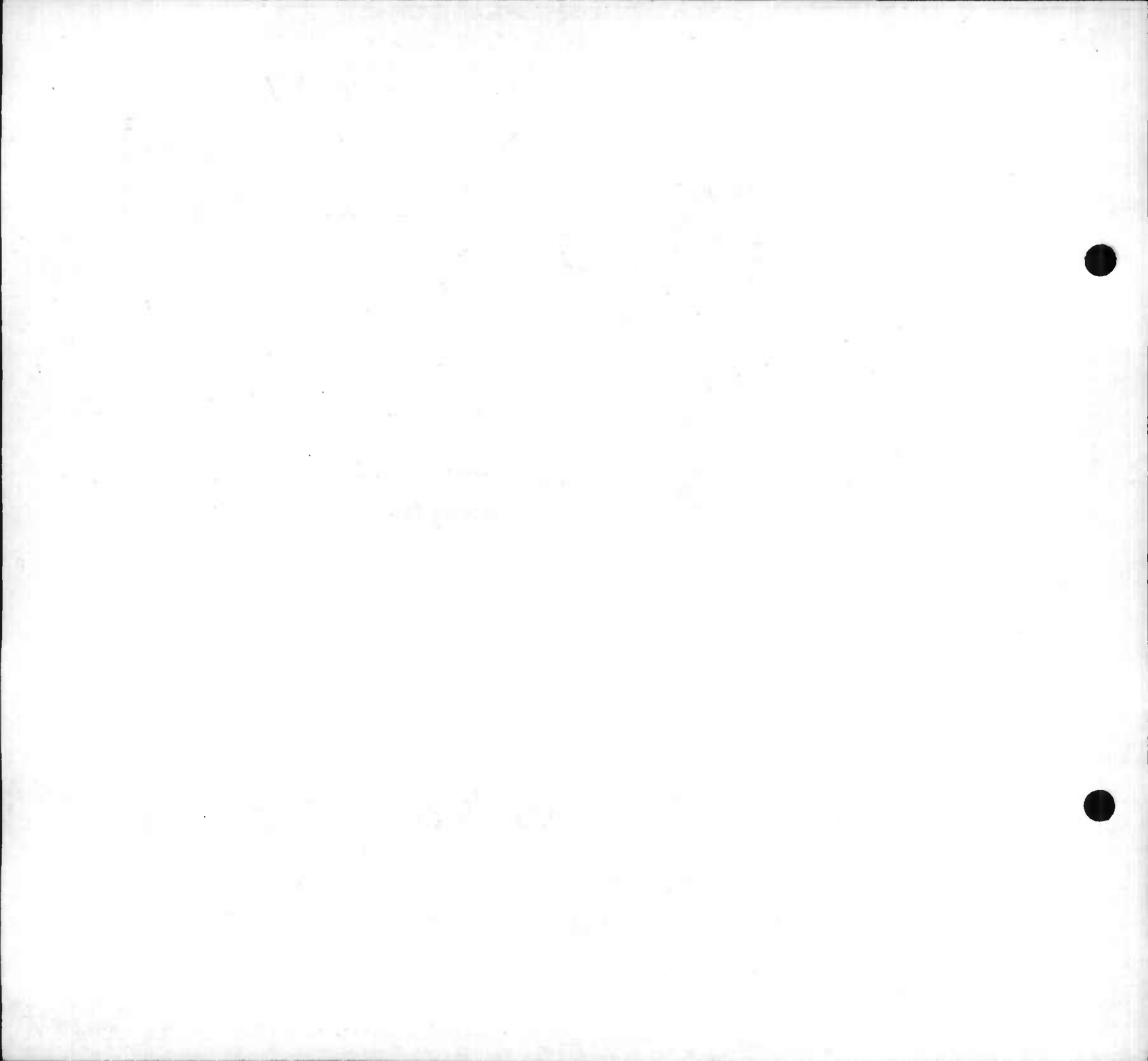
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|---|--|---|
| BIRTH NO. 66 09151 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09151 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Louise B. Mc Gehee. | | | Sept 7, 1966 6.30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3713 Elm Ave | | | A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3713 Elm Ave | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Oct 14, 1889 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 13. FATHER'S NAME Thomas M. Benson. | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no | | | 16. SOCIAL SECURITY NO. 212 32 2015 | | 17. INFORMANT ADDRESS Mrs. Wade Davis. 3713 Elm Ave. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH Coronary bednasion (A) DUE TO (B) DUE TO Arterio sclerotic (C) DUE TO C.V. Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Sensitivity INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1960 to Sept. 7th 1966, that (I) (we) lost saw the deceased olive on Sept 7th 1966 and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Paul Byerly | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) M. Paul Byerly | | | 23D. ADDRESS 5470 Fork Rd Bath 12 Md | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION Old Frederick Rd, Md | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR SEP 12 1966 | | 25C. FUNERAL DIRECTOR Justin E. Donovan - 3818 Roland Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09152 | |
|---|-------------------------|--|---|---|---|
| BIRTH NO. 66 09152 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Vazzano Rosario (Harry)</i> | | | 2. DATE AND HOUR OF DEATH <i>2:09 PM 9-9-66 2:09 PM.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i> | | | A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| 42 | | | D. STREET ADDRESS (If rural, give location) <i>235 N. Chester St. #31</i> | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3/26/03</i> | 9. AGE (In years last birthday) <i>63 y</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sgt. Police</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Police</i> | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Santo Vazzano</i> | | | 14. MOTHER'S MAIDEN NAME <i>Bridgette Yreto</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>-</i> | 17. INFORMANT <i>Beatrice H. Vazzano</i> ADDRESS <i>235 N. Chester St.</i> | |
| 18. <i>4331</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) <i>cardiac arrest</i> | | |
| ANTECEDENT CAUSES | | | (B) <i>arrhythmia (supraventric tachycardia)</i> | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> 19 <i>66</i> to <i>9/9</i> 19 <i>66</i> , that (I) <i>yes</i> last saw the deceased alive on <i>9/9</i> 19 <i>66</i> and that in (my) <i>Q</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>W</i> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>P. I. KWON</i> M.D. | | | | 23B. DATE SIGNED <i>9-9-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>P. I. KWON</i> M.D. | | | | 23D. ADDRESS <i>Sinai Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/13/66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore</i> | | 24E. STATE (State) <i>Md.</i> | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR <i>Philip Henry ...</i> ADDRESS <i>2024 ...</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|---|--|---|--|
| BIRTH NO. <u>66-18806</u> <u>66 09153</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>66 09153</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY GIRL KNOTTS</u> | | | 2. DATE AND HOUR OF DEATH <u>9-7-66</u> <u>1:30 P</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home + Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>BALTO</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore MD. 5300</u> D. STREET ADDRESS (If rural, give location) <u>26 FLAGSHIP RD.</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____ | 8. DATE OF BIRTH <u>9/7/66</u> | 9. AGE (In years last birthday) _____ | If Under 1 Yr. If Under 24 Hrs. Months: Days Hours: Min. <u>5 hrs.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u> | |
| 13. FATHER'S NAME <u>JAMES A. KNOTTS</u> | | | 14. MOTHER'S MAIDEN NAME <u>CECELIA GLASS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT <u>JAMES A. KNOTTS 26 FLAGSHIP - 21292</u> | |
| 18. <u>762.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>Intrauterine hemorrhage and</u> DUE TO <u>Cerebral anoxia</u> (B) <u>Intrauterine anoxia</u> DUE TO _____ (C) _____ | | |
| 19A. DATE OF OPERATION <u>9-7-66</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20A. AUTOPSY? (Yes or No) _____ |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 7</u> 19 <u>66</u> to <u>Sept 7</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Sept 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9-7-66</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Sudover, Jr.</u> | | | 23D. ADDRESS <u>Church Home + Hosp.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24B. DATE <u>9/12/66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR <u>ULRICH FUNERAL HOME - DUNDALK MD</u> | |

Balance 100

2000 - 1000 = 1000

Interest 1000

10/100

Interest 1000

Interest 1000

1000 + 1000 = 2000

66 09154

BALTIMORE CITY HEALTH DEPARTMENT

66 09154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

George Yursavage (Yurcavage)

2. DATE AND HOUR PRONOUNCED DEAD

9/8/66 11:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1926 Aliceanna St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

243 S. Washington St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 23, 1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ship Ceiler

10B. KIND OF BUSINESS OR INDUSTRY

Steamship Co.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Martin Yurcavage

14. MOTHER'S MAIDEN NAME

Anna Kowalewski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

202-09-2584

17. INFORMANT

ADDRESS

Mrs. Mary Benyock, 243 S. Washington St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardio-
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/9/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/12/66

23C. NAME OF CEMETERY or CREMATORY

Holy Rosary

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

M.F. SADOWSKI & SONS, 1808 EASTERN AVE

ADDRESS

WALLER POLICE

THE CITY

47-69-09

J-525 66 09155

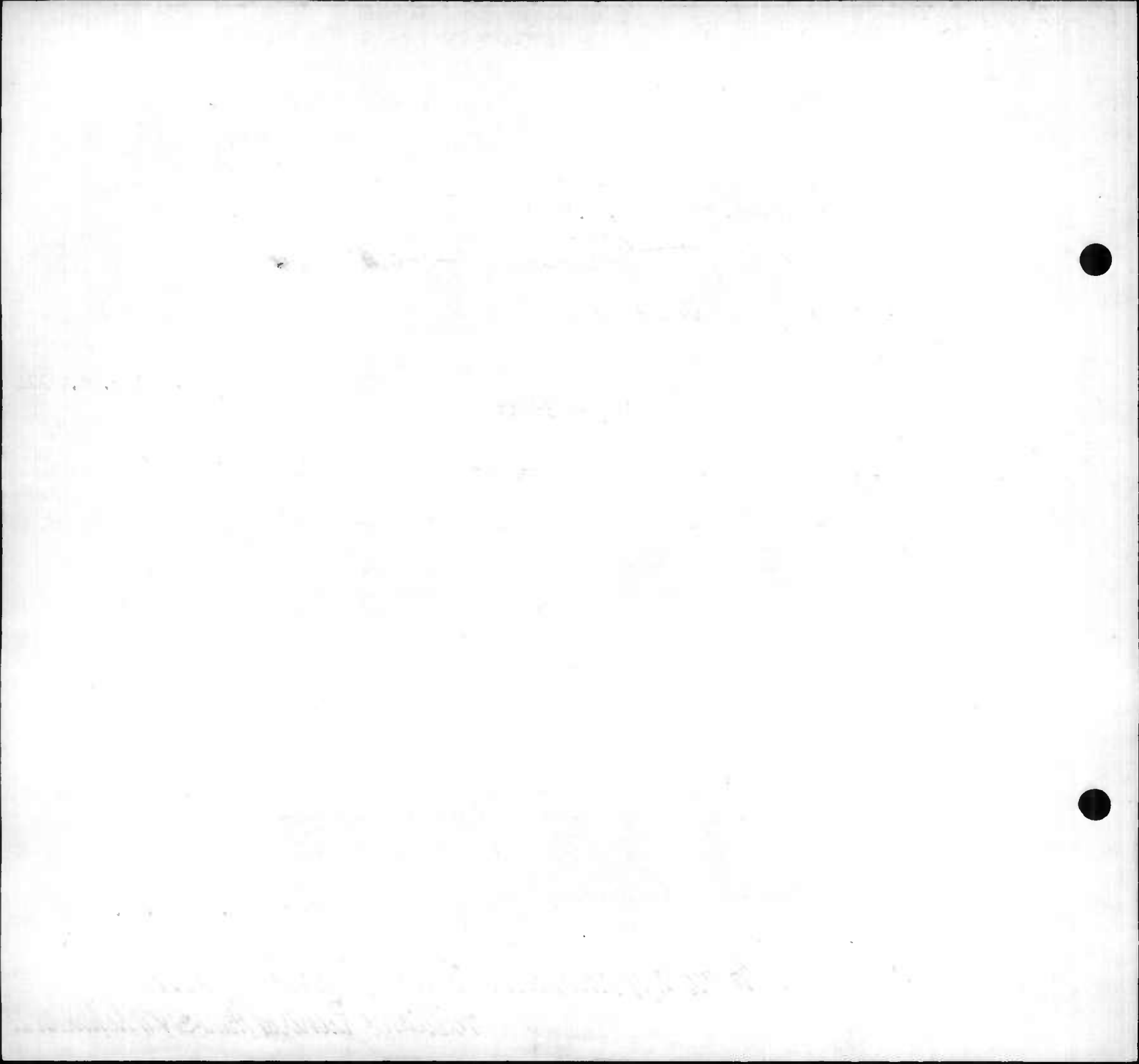
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09155

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

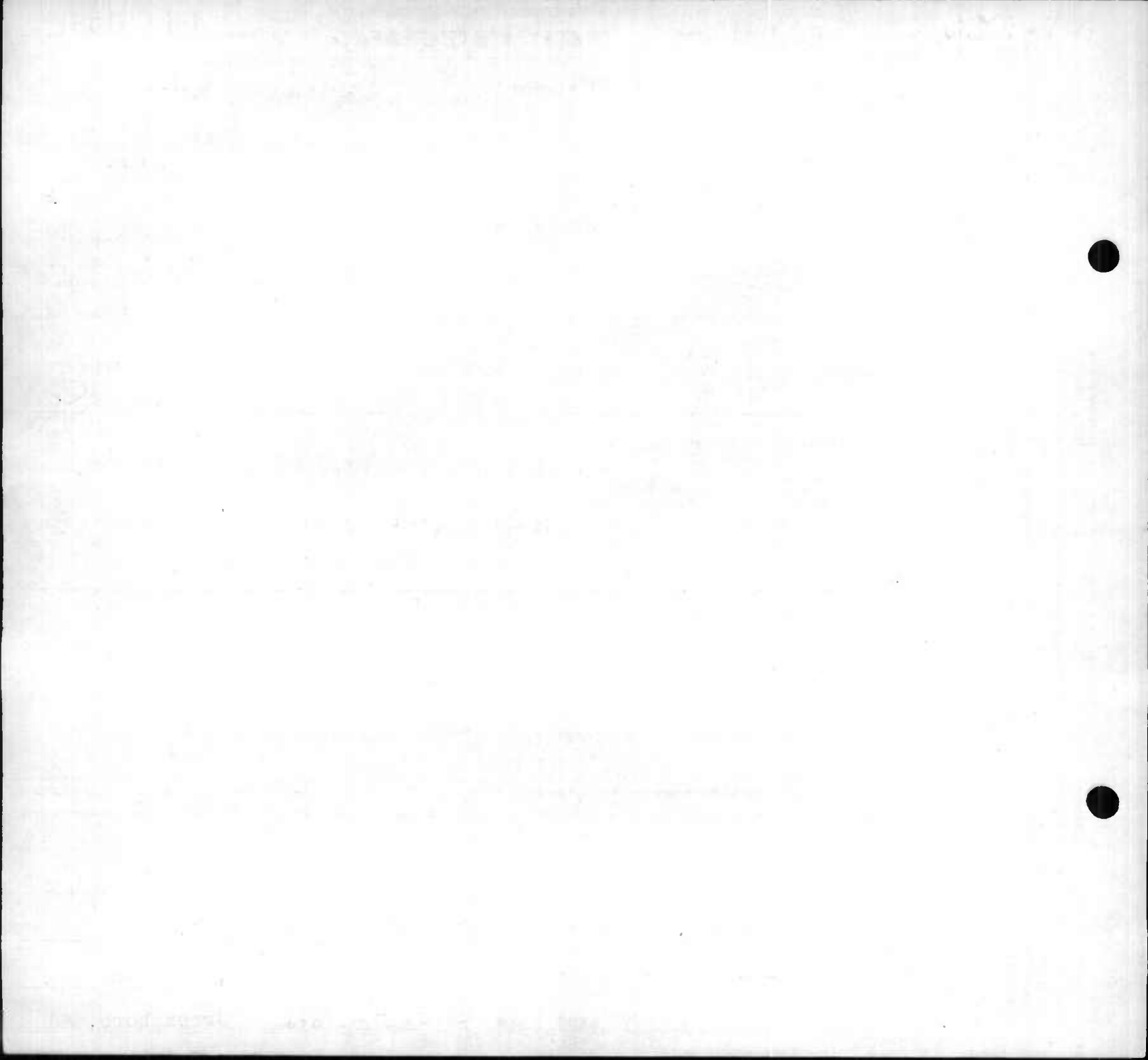
| | | | | | |
|--|----------------------|--|-----------------------------------|---|---|
| BIRTH NO. 66 09155 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09155 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Johnson, Walter H.</u> | | 2. DATE AND HOUR OF DEATH <u>9/8/66</u> <u>1945</u> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> | | 5. AGE (In years lost birthday) <u>64</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hosp</u> <u>4940 Eastern Avenue, Baltimore, Md. 21224</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location) <u>119 N. Carey St.</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH <u>6-1-02</u> | 9. AGE (In years lost birthday) <u>64</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u> Junk yard</u> | | 11. BIRTHPLACE (State or foreign country) <u>Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Walter Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Sena</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-03-5868</u> | | 17. INFORMANT <u>Chart</u> <u>BCH</u> <u>4940 Eastern Avenue, Balto. Md. 21224</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>199.2 I</u> | | CAUSE OF DEATH (A) <u>Myocardial infarction</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>carcinomatous</u> DUE TO | | <u>weeks - mo.</u> | |
| (C) <u>Uremia</u> DUE TO | | | | <u>3 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>66</u> to <u>Sept 8</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>Sept 8</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Mary Ann Sullivan</u> M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9-8-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Mary Ann Sullivan</u> M.D. | | 23D. ADDRESS <u>4940 Eastern Ave., Balto. Md. 21224</u> <u>Baltimore City Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Sept 12, 1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>W.H. Auburn Cem</u> | |
| 24D. LOCATION <u>Balto. Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| 25A. NAME OF REGISTRAR <u>Robert E. Fadden</u> | | 25B. FUNERAL DIRECTOR <u>Williams Funeral Home</u> | | 25C. ADDRESS <u>319 N. Howard St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

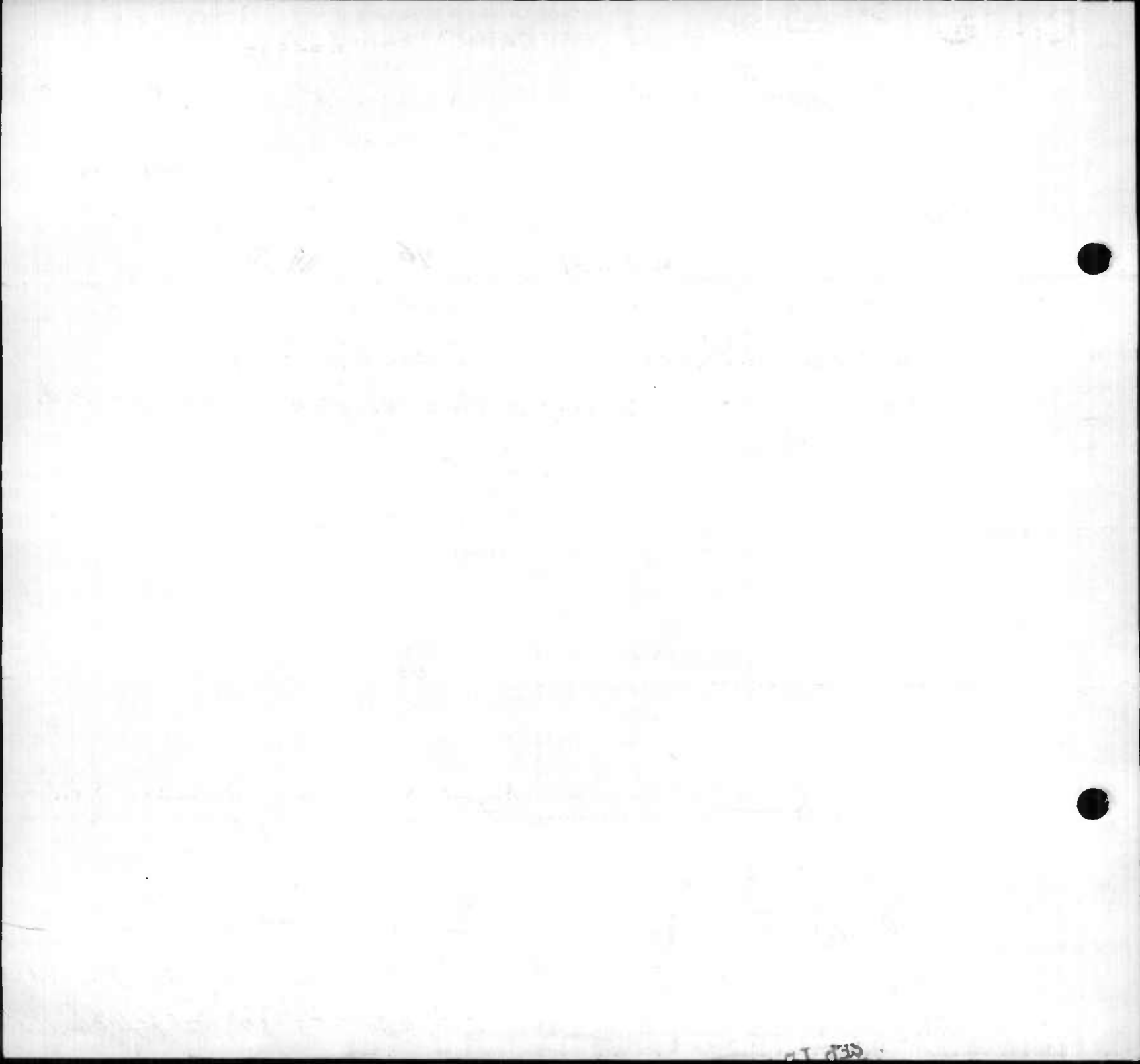
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09156 | |
|---|------------------|---|----------------------------|--|---|
| BIRTH NO. 66 09156 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Francis Herbert Murphy | | 2. DATE AND HOUR OF DEATH September 6, 1966 4:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Queens Anne Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Balto., Md 21201 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Church Hill 67-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) never married | 8. DATE OF BIRTH 5-8-66 | 9. AGE (In years last birthday) 4 mos | 10. If Under 1 Yr. Months: Days: Hours: Min. 4 1 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Francis Murphy | | 14. MOTHER'S MAIDEN NAME Lydia Dost | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT hospital record Balto, Md Lombard & Green | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 752X1 brain stem herniation | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 2 day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) hydrocephalus (non-communicating) | | 4 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/5/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED subdural effusion | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 4 1966 to Sept 6 1966, that (I) (we) last saw the deceased alive on Sept 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Franklin E. Johnson M.D. | | | | 23B. DATE SIGNED Sept 6/66 | |
| 23C. PHYSICIAN'S NAME (Type) Franklin E. Johnson M.D. | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-8-66 | | 24C. NAME OF CEMETERY or CREMATORY Greensboro | |
| 24D. LOCATION (City, town, or county) (State) Greensboro, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR J. E. Boulares | | 25C. FUNERAL DIRECTOR ADDRESS Greensboro, Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09157 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09157 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Washington T. Robinson | | 2. DATE AND HOUR OF DEATH 9/7/66 11:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00 D. STREET ADDRESS (If rural, give location) 201-7th Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH 9/7/76 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Calvert Co., Md. | |
| 13. FATHER'S NAME Oliver Robinson | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 28-18-4753 | | 17. INFORMANT Ellis Robinson ADDRESS Solomons, Md. | |
| 18. 4-22-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease | | CAUSE OF DEATH (A) CVA DUE TO (B) Arteriosclerotic Cardiovascular DUE TO Disease (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 15, 1966 to September 7, 1966 that (I) (we) last saw the deceased alive on September 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert C. Blackmon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon | | 23D. ADDRESS M.D. Lutheran Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 10, 1966 | | 24C. NAME OF CEMETERY or CREMATORY Solomons Methodist Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Solomons, Calvert Co., Md. | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. FUNERAL DIRECTOR A.A. Hargess & Son | | 24H. ADDRESS Port Republic, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09158 | | Registered No. 66 09158 | |
|--|--|---|--|--|--|--|--|
| BIRTH NO. 66 09158 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES A. BLOM | | | | 2. DATE AND HOUR OF DEATH Sept. 7, 1966 4 a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 702 N. Belnord Ave., Baltimore, Md. 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 7-02 | | | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED (Specify) Married | | 8. DATE OF BIRTH 3/21/1906 | |
| 9. AGE (in years lost birthday) 60 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt. of Guard-Eastern Stainless Steel | | 11. BIRTHPLACE (State or foreign country) Charleston, S. C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles A. Blom | | | | 14. MOTHER'S MAIDEN NAME Sarah I. Smith | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Lillian Graff Blom, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinomatous DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 months | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 12 1966 to Sept 7 1966, that (I) (we) last saw the deceased alive on Sept 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Isadore K. Grossman M.D. | | | | 23B. DATE SIGNED Sept 8, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Isadore K. Grossman M.D. | | | | 23D. ADDRESS 3409 Rosedale Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St. | | ADDRESS | |

12-12-21

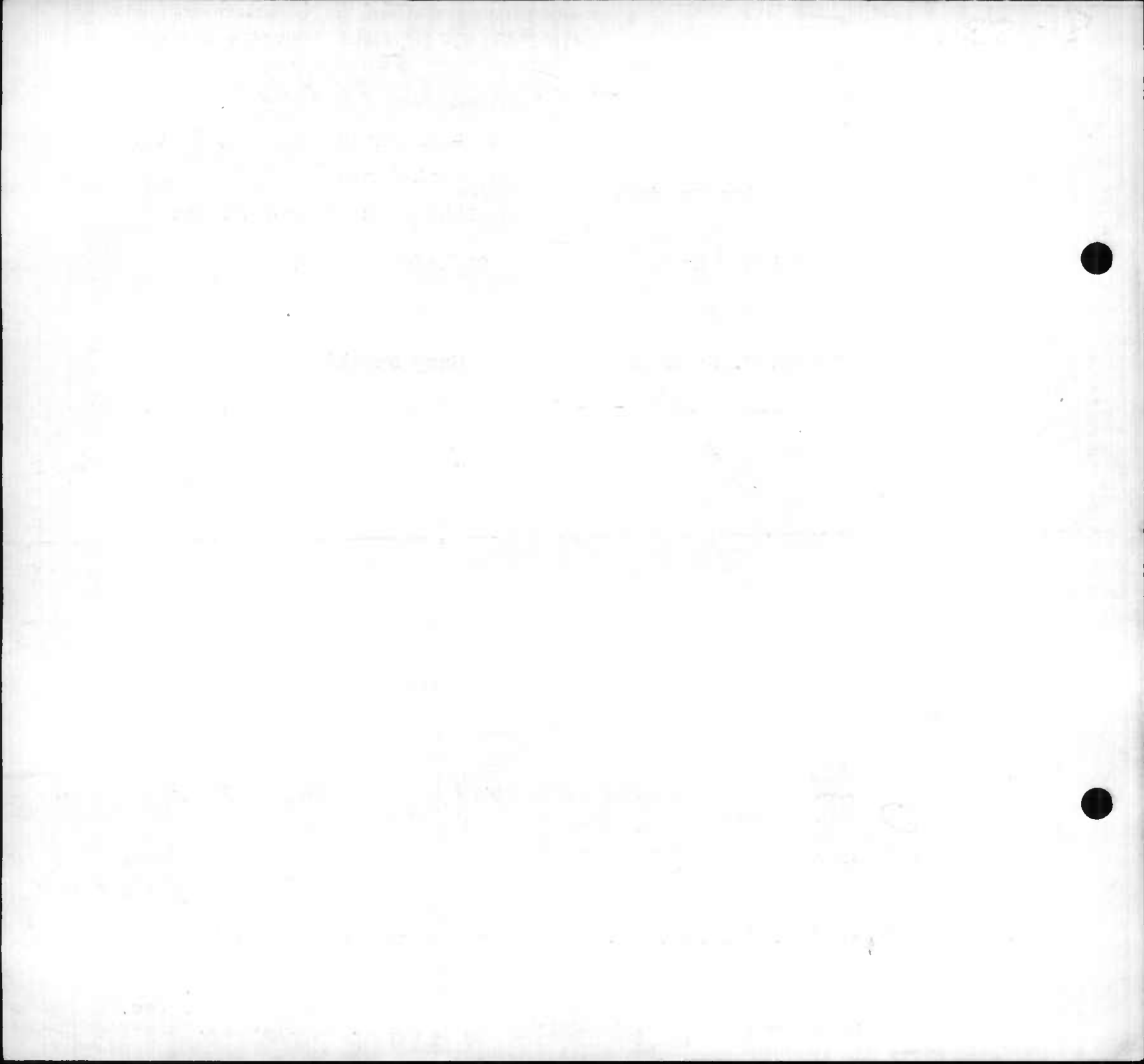
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12-12-21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|------------------------------|--|---|
| BIRTH NO. 66 09159 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09159 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Santora Joseph P. | | 2. DATE AND HOUR OF DEATH 9/8/66 12 noon M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY B Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2828 East Madison Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 08/14/93 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher | | 10B. KIND OF BUSINESS OR INDUSTRY B & O R R | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME Joseph W. Santora | | 14. MOTHER'S MAIDEN NAME Mary Stehlik | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 705-05-7965 | | 17. INFORMANT Hilda Kaisler Santora, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO CVA and pneumonia 2 days (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/6 1966 to 9/8 1966, that (I) (we) last saw the deceased alive on 9/8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard J. Owellen, MD. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) Richard J. Owellen, MD. | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Fickema | | 25C. ADDRESS 2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09160 | |
|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. <u>66 09160, Md.</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>FOOTE, Juanel</u> | | | 2. DATE AND HOUR OF DEATH <u>9-6-66</u> <u>8:30 PM</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS Hospital</u> | | | A. STATE <u>Md.</u> B. COUNTY <u>114</u> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Edgewater</u> | | |
| 5. SEX <u>Male</u> 6. RACE <u>N</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>—</u> | | | D. STREET ADDRESS (If rural, give location) <u>RT 4 Box 624 Edgewater Md</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 8. DATE OF BIRTH <u>11-13-65</u> | | 9. AGE (In years last birthday) <u>10</u> |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13. FATHER'S NAME <u>LEON MATTHEWS</u> | | | 14. MOTHER'S MAIDEN NAME <u>GERALDINE FOOTE</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Geraldine Foote Edgewater Md</u> | |
| 18. <u>757.11</u> CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) <u>MENINGITIS</u> DUE TO (B) <u>HYDROCEPHALUS</u> DUE TO (C) <u>HYDROCEPHALUS</u> | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>this hospital</u> attended the deceased from <u>11/15</u> 19 <u>65</u> to <u>9/6</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>9/6/66</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>9/6/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. M. WHITEWORTH</u> | | | | 23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-9-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Cherry Memorial</u> | |
| 24D. LOCATION (City, town, or county) <u>Owensville Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>William Rees</u> | |
| 25C. FUNERAL DIRECTOR <u>William Rees</u> | | 25D. ADDRESS <u>[Signature]</u> | | | |

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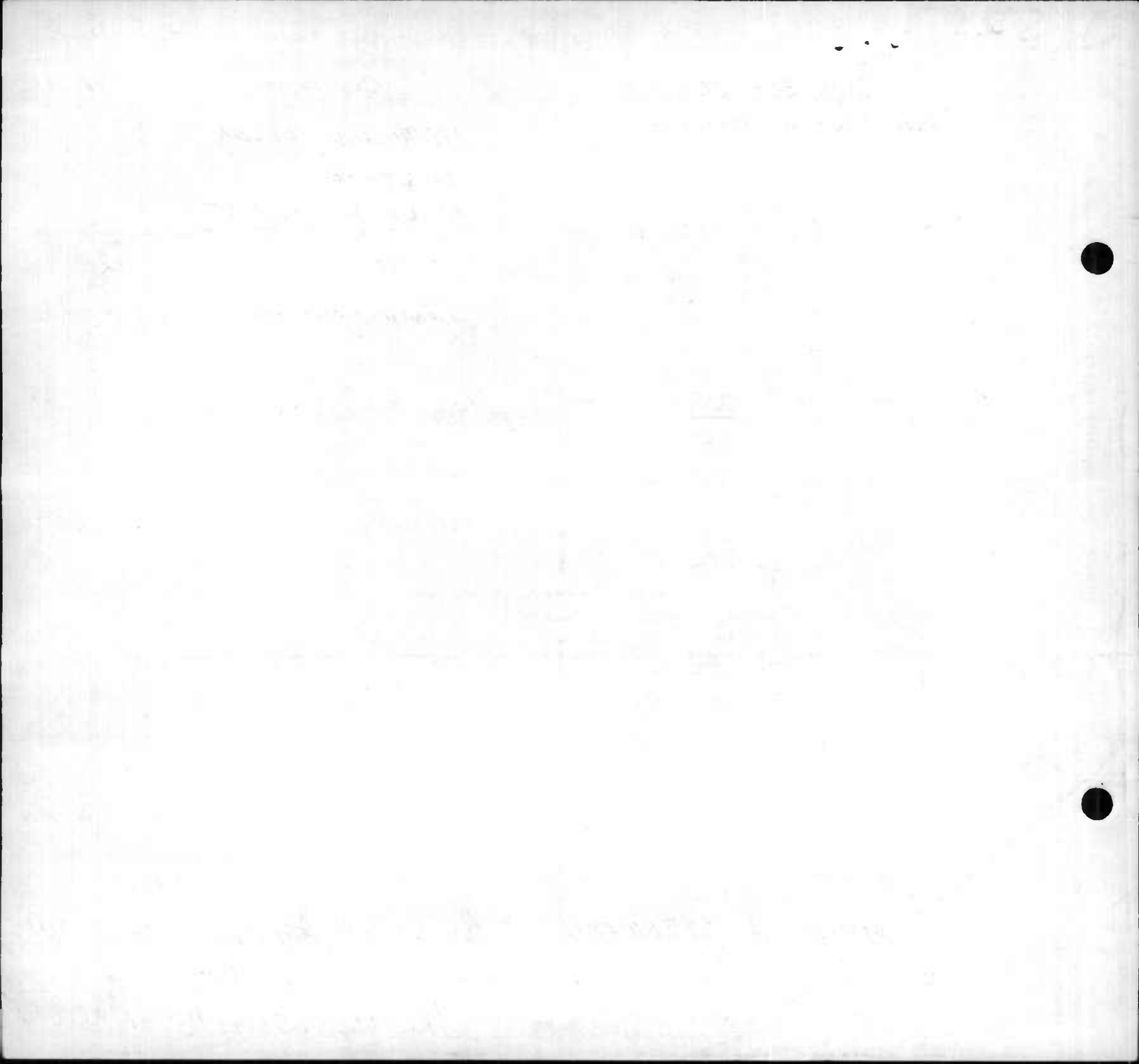
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|----------------------------|--|---|--|--|
| 66-17237 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09161 | |
| BIRTH NO. 66 09161 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BABY BOY JOHNSON | | 2. DATE AND HOUR OF DEATH Aug. 19, 1966 12:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND BON SECOURS HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21223 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2540 Lombard ST | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 8-18-66 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| | | | Hospital Records | | |
| 18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Atletism (B) Prematurity (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alexander A. Melacotron | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 8/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) ALEXANDER A. MELACOTON | | 23D. ADDRESS Bon Secours Hospital, Balt MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9/8/66 | 24C. NAME of CEMETERY or CREMATORY St Peters Cem | | 24D. LOCATION (City, town, or county) (State) Baeto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Feltz | | 25C. FUNERAL DIRECTOR Thomas J. Kenny Inc | |
| | | | | ADDRESS Baeto Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|--|--------------------------------------|--|---|
| BIRTH NO. 66 09162 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09162 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) <i>Rosana Hermann</i> | | 2. DATE AND HOUR OF DEATH <i>9/10/66 10:15 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>2101</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 792 W. Cross St.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>792 W. Cross St.</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>2/11/1881</i> | 9. AGE (In years last birthday) <i>85</i> | 10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 13. FATHER'S NAME <i>Thomas H. Little</i> | | 14. MOTHER'S MAIDEN NAME <i>Clara Belle Causey</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT ADDRESS <i>Mrs Elsie Webb above</i> | |
| 18. <i>334X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Cerebral Arteriosclerosis</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/16</i> 19 <i>64</i> to <i>9/10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/9</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>John P. Urlock Jr</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/10/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i> | | 23D. ADDRESS <i>1227 Wash. Blvd</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/14/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd.</i> | | 25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 12 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i> | | 25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i> | | | |
| 25D. ADDRESS <i>23 Md.</i> | | | | | |

General (Cottrell)

3/18/50

2/4/50

John O. Warden Jr.

and P. Warden Jr.

Released to Univ. Hosp - per M.E.O. 9/16/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09163 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09163 | |
|---|---------------------|--|--|--|--|--|------------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GEORGE M. WILLIAMS | | 2. DATE AND HOUR OF DEATH 9-9-66 | | M. 11 A | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE Baltimore | | B. COUNTY Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City | | 1703 | |
| | | | | D. STREET ADDRESS (If rural, give location) 743 W. FRANKLIN ST | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 4/19/19 | 9. AGE (In years lost birthday) 47 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George McWilliams | | | | 14. MOTHER'S MAIDEN NAME Mary | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr Winfred McWilliams, 3923 Glen Hunt Rd | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 416 X I Constrictive Heart Failure Cardiac Standstill | | | | CAUSE OF DEATH (A) DUE TO Rheumatic Heart Disease (B) DUE TO unknown (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 9 19 66 to Sept 9 19 66 , that (I) (we) last saw the deceased alive on Sept 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE B. PORTNOY | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) B. PORTNOY | | | | 23D. ADDRESS M.D. UNIVERSITY HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/13/66 | | 24C. NAME of CEMETERY or CREMATORY National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave | | | |

UNIVERSITY HOSPITAL
313 W. FRANKLIN ST.
CHICAGO, ILL.

March 1914

Rheumatic Heart Disease
Cardiac Tamponade
Congestive Heart Failure

Yes

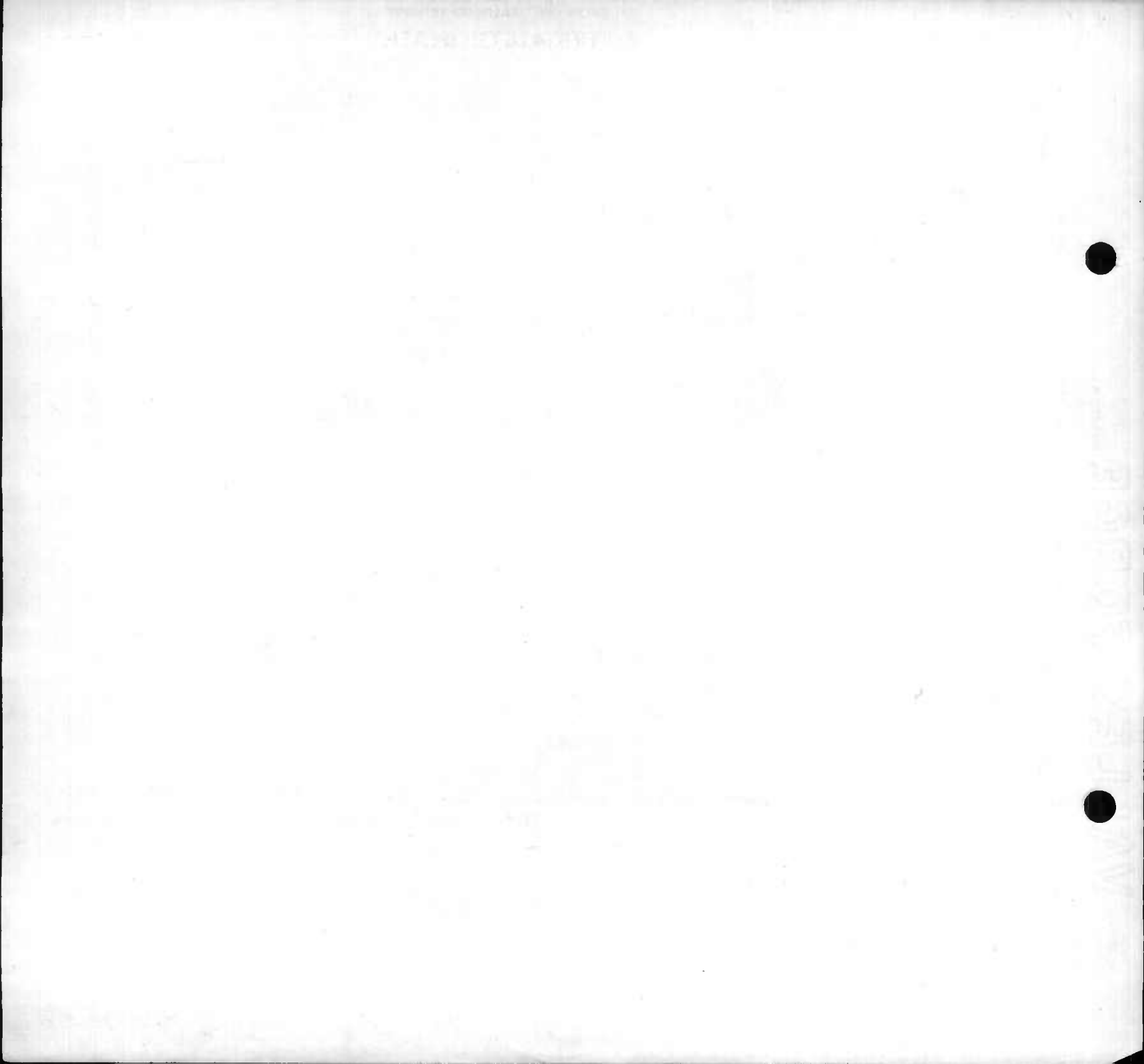
UNIVERSITY HOSP

CHICAGO
ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 66 09164 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09164 | |
| 1. NAME OF DECEASED (Type or Print) Morris J. Coyle | | | 2. DATE AND HOUR OF DEATH Sept. 9th 1966 5:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 24-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION House of The Pines Nursing Home. Bel Air Rd., Balto. Md. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| D. STREET ADDRESS (If rural, give location) 1351 Jackson St. | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH 12/16/04 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard Worker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME unk | | |
| 14. MOTHER'S MAIDEN NAME unk. | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no | | |
| 16. SOCIAL SECURITY NO. 215-05-7228 | | | 17. INFORMANT Jewis Metzler ADDRESS 42 S. Leinster Columbus Hill Md | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 334X1 Acute Pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATELECTASIS | | | DUE TO weeks | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple episodes of Pneumonia | | | 6 mos. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/25 1963 to 9/9/1966 , that (I) (we) last saw the deceased alive on 9/8/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert D. Bradley | | | 23B. DATE SIGNED 9/9/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Ceme. |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | | 25C. FUNERAL DIRECTOR McGulley ADDRESS 130 E 90th Ave. | | |



66 09165

BALTIMORE CITY HEALTH DEPARTMENT

66 09165

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SHIRLEY

ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

September 4, 1966

10:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4039 Annellen Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

3/17/1939

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stapler

10B. KIND OF BUSINESS OR INDUSTRY

Luggage Factory

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Eclair Ingram

14. MOTHER'S MAIDEN NAME

Catherine Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war & dates of service)16. SOCIAL
SECURITY NO.

226-548712

17. INFORMANT

ADDRESS

Natti Dow 58-16th St. Patterson
N. J.

18.

E 981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Shotgun wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

9-1-66

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4039 Annellen Road

21D TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

September 1, 1966 8:30

A.M.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot by boy-friend

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURECharles S. Springate, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 5, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/9/66

23C. NAME OF CEMETERY or CREMATORY

Carver Mem. Ph.

23D. LOCATION

Laurel

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Wilmington Phillips 1727 N. Monmouth

ADDRESS

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09166 | |
|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | Registered No. 66 09166 | |
| BIRTH NO. 66 09166 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WALKER, VERNON | |
| 2. DATE AND HOUR OF DEATH 9-8-66 11:00 AM | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX MALE | | | |
| A. STATE MARYLAND | | 6. RACE NEGRO | | | |
| B. COUNTY 15-07 | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 8. DATE OF BIRTH 3-11-13 | | | |
| D. STREET ADDRESS (If rural, give location) 2010 MCKEAN AVE. 21217 | | 9. AGE (In years last birthday) 53 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Josephine Gross | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 47-07-942 | | 17. INFORMANT Rudolph Walker ADDRESS 3901 Carlisle Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) MASSIVE GASTROINTESTINAL BLEEDING. 5 MINUTES. | | | |
| ANTECEDENT CAUSES | | (B) METASTATIC CANCER TO LIVER | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) BRONCHOGENIC CARCINOMA. | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sep. 5 19 66 to Sep. 8 19 66 that (I) (we) last saw the deceased alive on Sep 8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim | | | | 23B. DATE SIGNED 9-8-66 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. P.R. Arbutus, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Parker | | 25C. FUNERAL DIRECTOR Arlington S. Phillips ADDRESS 1727 N. Monroe St | | | |

7-8-66

7-8-66

LABORATORY REPORT

31-11-66

100

Metastatic cancer to liver
carcinoma

10

10

LABORATORY REPORT

LABORATORY REPORT

1
B-460

66 09167

BALTIMORE CITY HEALTH DEPARTMENT

66 09167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | |
|---|---------|--|----------------------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| CRITTERON BLAIR | | September 6, 1966 4:15 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | |
| 1409 Mc Culloh Street | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 1409 McCulloh Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | Negro | UNKNOWN | 4/3/00 |
| 9. AGE (In years last birthday) | | 10. BIRTHPLACE (State or foreign country) | |
| 66 | | Baltimore Md | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF | |
| | | U.S. COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Jordan Blair | | Adaline Blunt | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| ? | | 216-05-0395 | |
| 17. INFORMANT | | ADDRESS | |
| Mrs Mary Curry | | 1801 Madison Ave | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| Hypertensive and arteriosclerotic heart disease | | | |
| (A) DUE TO | | | |
| (B) DUE TO | | | |
| (C) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| No | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| | | | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED | |
| Charles S. Springate, M.D. | | September 7, 1966 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 9/10/66 | |
| 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Mt Calvary Cemetery | | A A County Md | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| SEP 12 1966 | | Robert E. Farber, M.D. | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| Adolphus Halstead | | 1206 W N orth Ave | |

19660009167

00100 80

11:11

11:11

11:11

11:11

11:11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 66 09168 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09168 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) PHILLIPS, IDA ESTELLE | | 2. DATE AND HOUR OF DEATH 4, 55 AM, Sept 10 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 9-20-66 | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital | | D. STREET ADDRESS (If rural, give location) 632 GORSUCH AVENUE | | 6. DATE OF BIRTH 1883 6-28-1913 | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | |
| 13. FATHER'S NAME WILLIAM H KLINE | | 14. MOTHER'S MAIDEN NAME MARGARET ARMACOST | | 12. CITIZEN OF WHAT COUNTRY? American | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-15-4258-F | | 17. INFORMANT ADDRESS Miss Anita A. Phillips 632 Gorsuch Ave. - Zone 18 | |
| 18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Vascular Accident about 24 hrs (B) Hypertension (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Sept 9, 2:30 PM 1966 to Sept 10, 5:00 AM 1966 , that (2) (we) last saw the deceased alive on Sept 10, 4:55 AM 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. W. Song | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 10, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) S. W. SONG | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 9-13-66 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Witzke, F. D. - 4101 Edmondson Av. | |

9/20/66

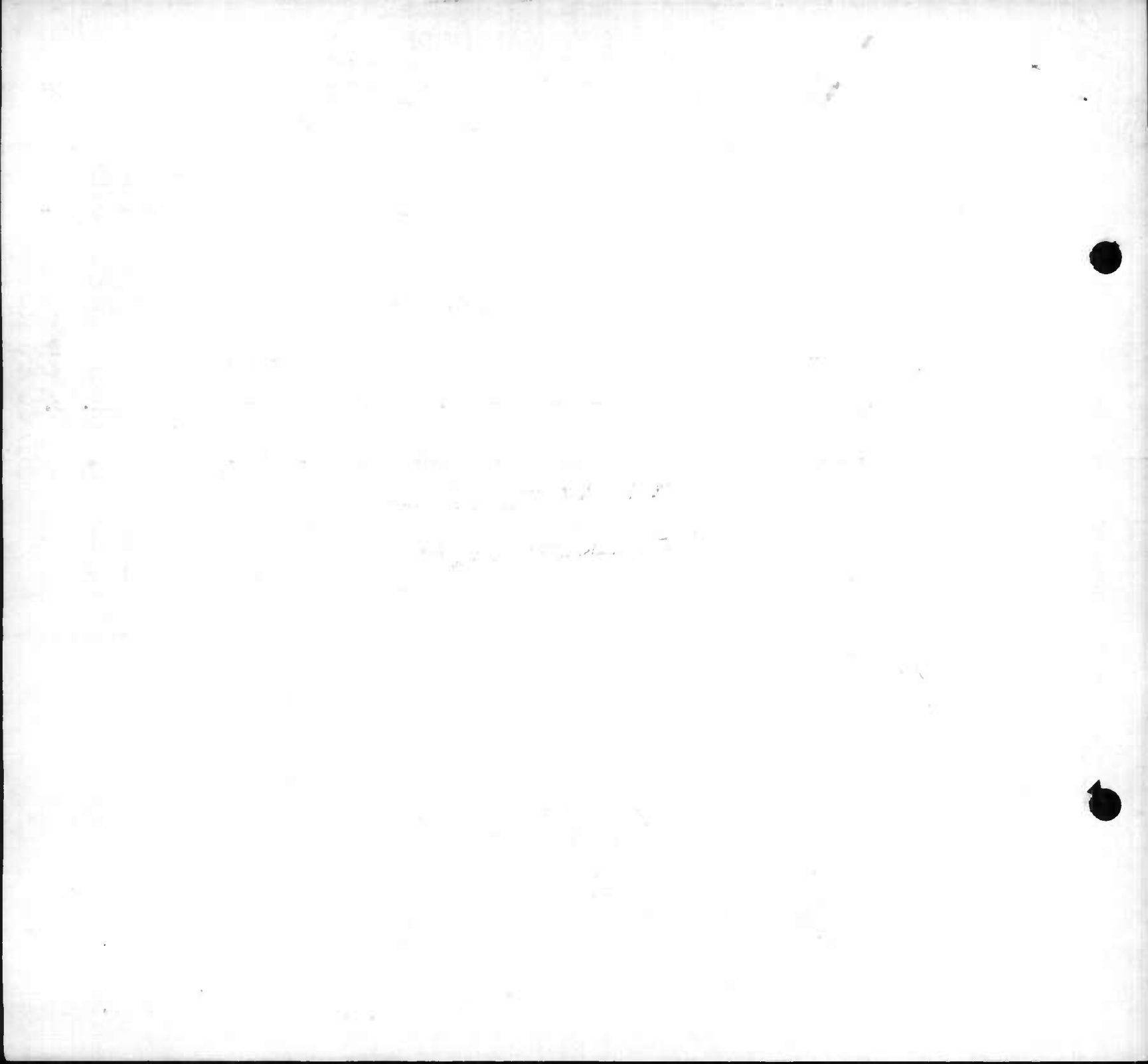
Corrected by Union Memorial Hospital Admission History Sheet.

[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

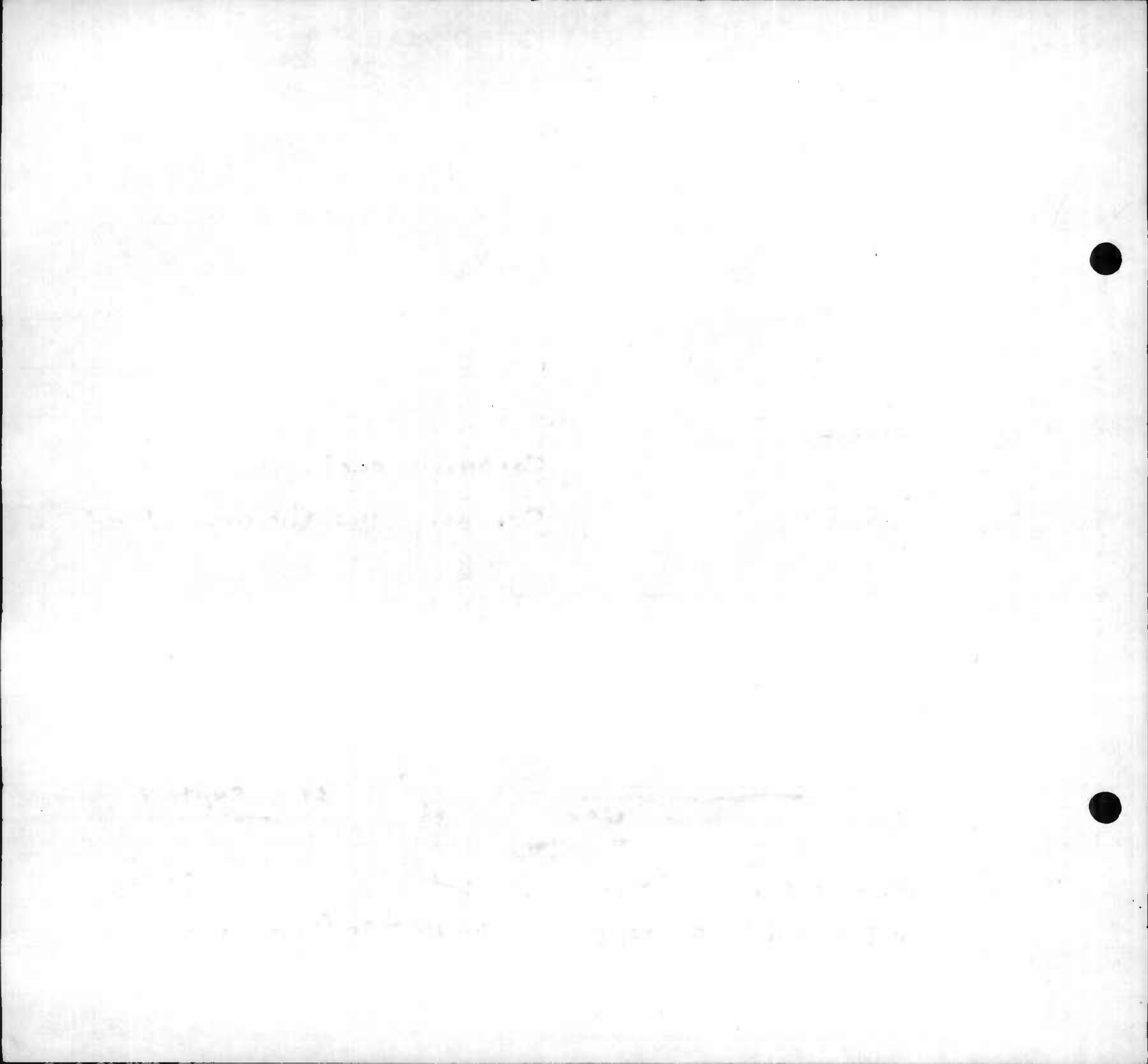
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09169 | |
|--|---------------------|---|------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09169 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Mullen, Ernest | | 2. DATE AND HOUR OF DEATH 9-8-66 11:12 PM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp. of Balt. | | A. STATE Md. B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 11 Warren Park Drive -Apt.C-4 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 6/10/04 | 9. AGE (In years lost birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Department Store | | 11. BIRTHPLACE (State or foreign country) Wash. D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Late -----Mullen | | 14. MOTHER'S MAIDEN NAME Late Grace ----- | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 4-83-1256 | | 17. INFORMANT Mrs. Myrtle Mullen-11 Warren Pk. Dr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ruptured abdominal aortic aneurism | | 19. CAUSE OF DEATH ruptured abdominal aortic aneurism | | 20. INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 9-8-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aneurism | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6:00 PM 9-8-66 to 11:12 PM 9-8-66 , that (I) (we) last saw the deceased alive on 9-8-66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE L. J. Moglen | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) L. J. Moglen | | 23D. ADDRESS Sinai Hosp. of Balt. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem. | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Carley, M.D. | | 25C. FUNERAL DIRECTOR Witzke F.D.-4101 Edmonds on Av. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09170 | |
| BIRTH NO. 66 09170 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Martha Gerozak | | 9-9-66 1 15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 6103 WALTHER BLVD. | | A. STATE MD | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | |
| | | 6103 WALTHER BLVD. | |
| 5. SEX Female | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 6. RACE WHITE | | BALTIMORE MD 2-7-34 | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | D. STREET ADDRESS (If rural, give location) | |
| 8. DATE OF BIRTH MAY 19-88 | | 6103 WALTHER BLVD. | |
| 9. AGE (In years last birthday) 78 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| BALTIMORE | | USA | |
| 13. FATHER'S NAME JOHN KOWALSKI | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT DANIAL GEROZAK SON | |
| 18. 420-11 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) CORONARY OCCLUSION 5min | |
| ANTECEDENT CAUSES | | (B) CORONARY INSUFFICIENCY 14mos | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to Sept 9, 1966 , that (I) (we) last saw the deceased alive on Jan. 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ronald Jandorf | | 23B. DATE SIGNED 9-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) R Donald Jandorf | | 23D. ADDRESS 6077 Hartford Rd | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 12, 66 | |
| 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Jandorf | |
| 25C. FUNERAL DIRECTOR Fred W. Gzazewski | | 25D. ADDRESS 1930 Eastern Ave | |



1
Y-620

66 09171

BALTIMORE CITY HEALTH DEPARTMENT

66 09171

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Benjamin

Yurek

2. DATE AND HOUR PRONOUNCED DEAD

9-9-66

11:42

p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-05

D. STREET ADDRESS (If rural, give location)

723 Umbra St.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5-5-1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Police officer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Yurek

14. MOTHER'S MAIDEN NAME

Frances Ruzinski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Intracerebral hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hypertensive cardiovascular disease
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, MD

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 13. 66

23C. NAME of CEMETERY or CREMATORY

Holy Rosary

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 12 1966

Robert E. Fisher, MD

Fred W. Ogasawara, 1930 Eastern Ave

1

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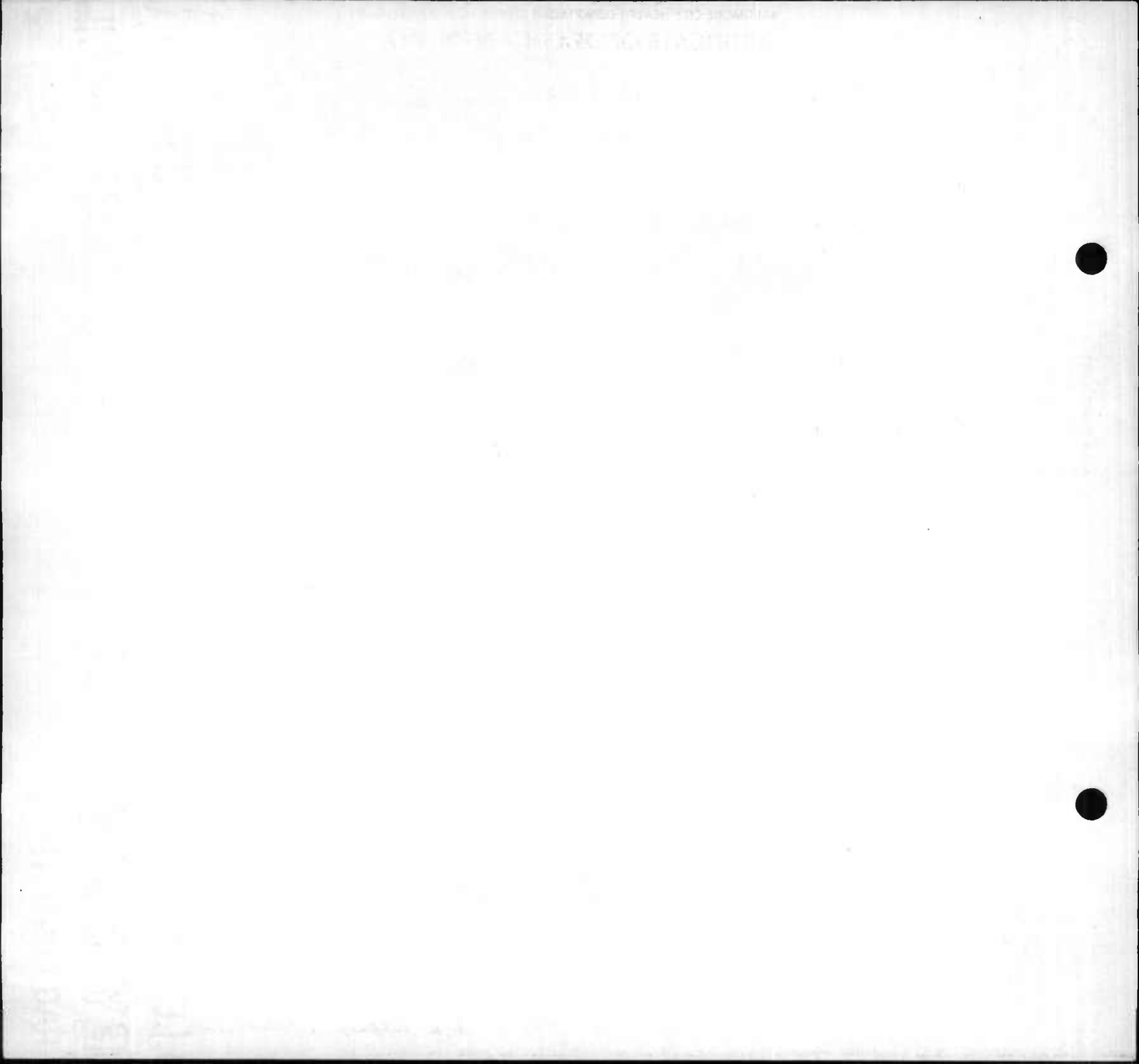
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

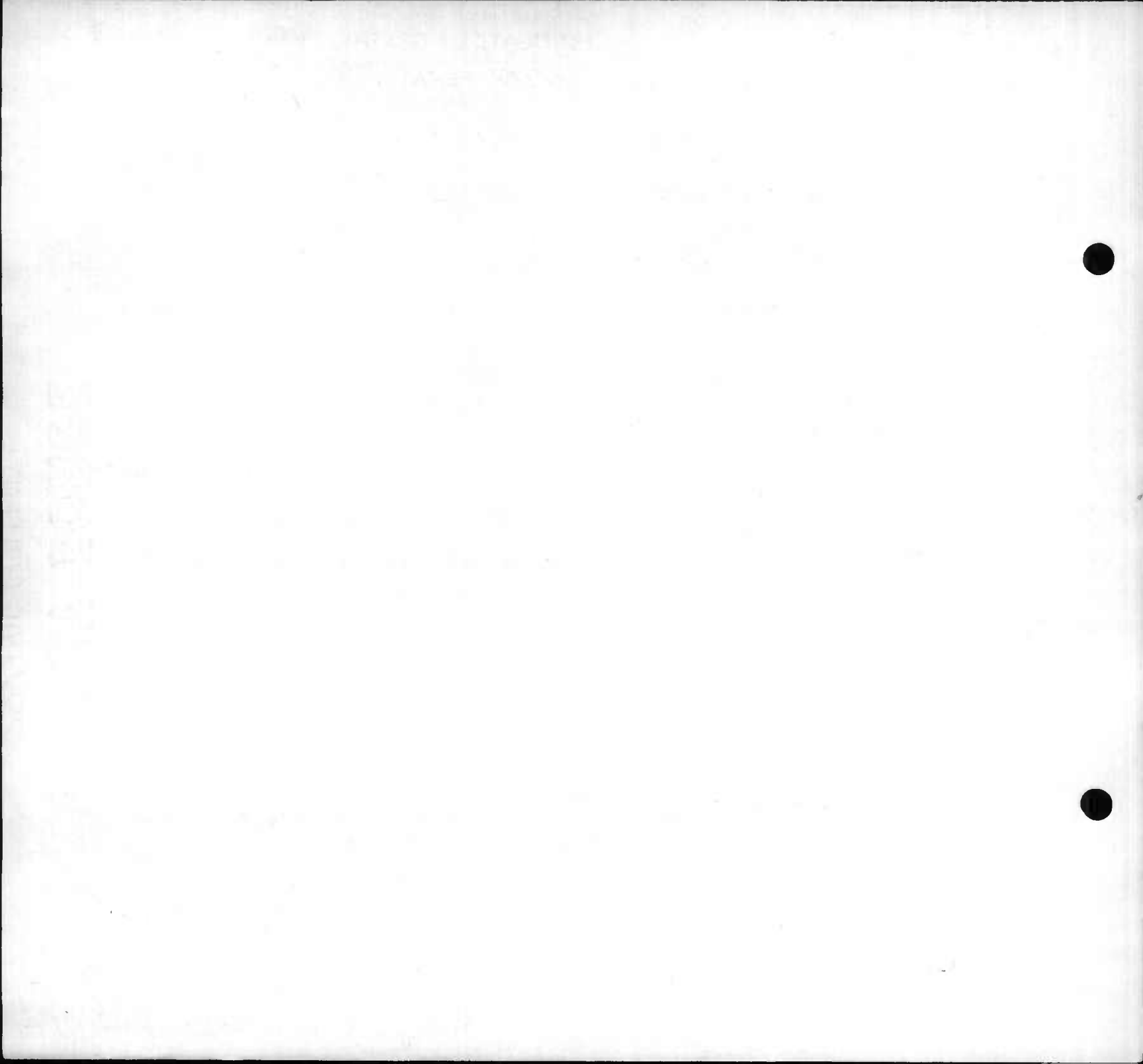
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09172 | |
|--|---------|--|------------------|--|-----------------------------|
| 66 09172 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | John R. Graham | | 7-1-66 7:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Maryland 22-01 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | Baltimore #21230 | |
| South Baltimore General Hosp. | | 629 S. Charles St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | Negro | Separated | 12/20/30 | 35 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Va. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Isador Graham | | Mabel Eddie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Verdella Robins | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | Broncho pneumonia | | | |
| 19. ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | QVA | | | |
| (B) DUE TO | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | YES. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (this hospital) attended the deceased from 7-31-1966 to 9-1-1966, that (we) last saw the deceased alive on 9-1-1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Camilo C. Balacait Jr. | | | | 9-6-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Camilo C. Balacait Jr. | | | | South Baltimore General Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-9-66 | | mt Calvary | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 12 1966 | | Robert E. Fisher | | T. L. Brown & Son 108 W. Montgomery St. | |



FUNERAL DIRECTOR: IMPORTANT

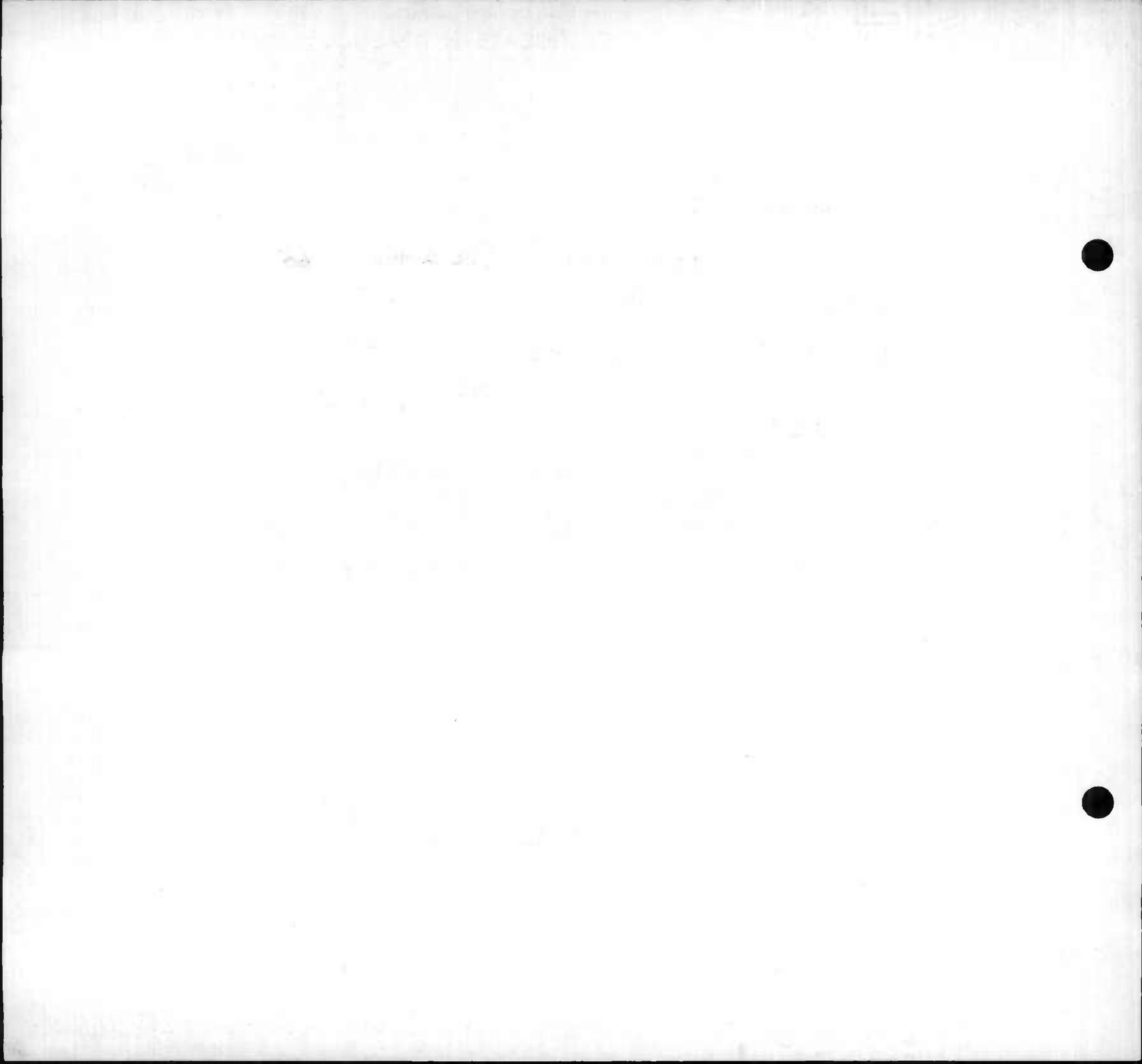
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09173 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09173 | |
|---|-----------------------------|---|--------------------------------------|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ZETTLEMOYER, HELEN FERN | | 2. DATE AND HOUR OF DEATH 9/11/66 3:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE PENN. B. COUNTY V-35 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S.P.H.S. HOSP. BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) AUBURN | | | |
| | | D. STREET ADDRESS (If rural, give location) R.D. 1 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 12/6/1941 | 9. AGE (In years last birthday) 24 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER-CLOTHES FOLDER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENN. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME BENJAMIN ZETTLEMOYER | | 14. MOTHER'S MAIDEN NAME EVA STRAUSSER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. UNK | | 17. INFORMANT ADDRESS ADMISSION SHEET | |
| 18. 204.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) GRAM NEG. SEPTICEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) GRAM NEG. SEPTICEMIA DUE TO (B) PERIRECTAL ABSCESS DUE TO (C) CHRONIC MYELOGENOUS LEUKEMIA | | INTERVAL BETWEEN ONSET AND DEATH 1 day several days MAY 1963 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30 1966 to 9/11 1966 , that (I) (we) last saw the deceased alive on 9/11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard L. Wesenberg | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> O.P. | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD L. WESENBERG | | 23D. ADDRESS U.S.P.H.S. HOSP. BALT., MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9/11/66 | 24C. NAME OF CEMETERY or CREMATORY ZION RED CHURCH CEM. | | 24D. LOCATION (City, town, or county) (State) WEST BURNSWICK SCHUYLKILL CO PENNA | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Wm J. Tickner & Sons Balt. 17 Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09174 | |
| BIRTH NO. 66 09174 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9-10-66 11:30 A.M. | |
| 1. NAME OF DECEASED (Type or Print) CHARLES H. WHITE | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DUKELAND NURSING HOME 901501 DUKELAND ST. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 3-02 D. STREET ADDRESS (If rural, give location) 217 PRESIDENT ST | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH DEC 2 1900 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK | | 10B. KIND OF BUSINESS OR INDUSTRY FOOD | 9. AGE (In years last birthday) 65 |
| 11. BIRTHPLACE (State or foreign country) N.J. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FREDERICK White | | 14. MOTHER'S MAIDEN NAME HENJS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT MRS. CLARA SCHAFER 6118 ALMA ST PHILA. PA | | ADDRESS | |
| 18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CHRONIC MYOCARDITIS | | INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (C) HEPATIC CIRRHOSIS | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC BRAIN SYNDROME | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-13 1966 to 9-10 1966 , that (I) (we) lost saw the deceased alive on 9-10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Thomas W. Harris | | 23B. DATE SIGNED 9-10-66 | |
| 23C. PHYSICIAN'S NAME (Type) THOMAS W. HARRIS | | 23D. ADDRESS M.D. 1824 W. FRANKLIN ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 9/11/66 | |
| 24C. NAME OF CEMETERY or CREMATORY ? | | 24D. LOCATION (City, town, or county) (State) PHILADELPHIA PA. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Wm J. Tichner & Sons | |
| 25C. FUNERAL DIRECTOR Balt 17 Md. | | ADDRESS | |



1
M-236

66 09175

BALTIMORE CITY HEALTH DEPARTMENT

66 09175

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|-------------------------|---|---|---|---|--|---------------------------------------|
| 1. NAME OF DECEASED (Type or Print) ANNA MASTRECOLA | | | | 2. DATE AND HOUR PRONOUNCED DEAD September 7, 1966 1:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-01 D. STREET ADDRESS (If rural, give location) 512 N. Curley Street | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Oct. 20, 1900 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Penn. | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME Benjamin Group | | | | |
| 14. MOTHER'S MAIDEN NAME ? | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. 216-24-6197 | | | 17. INFORMANT ADDRESS 542 Oxford Street Mrs. Cecelia Fazzino Brooklyn, N. Y. | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO (A) Arteriosclerotic Cardiovascular Disease. (B) Arteriosclerotic Cardiovascular Disease. (C) Arteriosclerotic Cardiovascular Disease. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/8/66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/12/1966 | | 23C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 24B. NAME OF REGISTRAR Robert E. Fickman | | 24C. FUNERAL DIRECTOR Wm J. Tichman | | | 24D. ADDRESS Baltimore, Md. |

WALTER HENRY

THE END

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--------------|---|------------------------------|--|---|
| BIRTH NO. 66 09176 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09176 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Birnbaum, SYLVAN | | 2. DATE AND HOUR OF DEATH Sept 10 - 1966 11:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) Md. BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP. | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 1001 ST. PAUL ST. APT | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 11-11-87 | 9. AGE (In years last birthday) 78 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Edison Co. | | 10B. KIND OF BUSINESS OR INDUSTRY Elect. Eng. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME MAX BIRNBAUM | | 14. MOTHER'S MAIDEN NAME CELIA UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 012-07-5975 | | 17. INFORMANT Mr. Samuel J. Fisher | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE | | 19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | 20. INTERVAL BETWEEN ONSET AND DEATH 36 hours | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 8 1966 to Sept 10 1966, that (I) (we) last saw the deceased alive on Sept 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sidney E. Kirkley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 10, 66 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | M.D. UNION MEM. HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/1966 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Wm. J. Fisher | |
| 25C. FUNERAL DIRECTOR Wm. J. Fisher | | 25D. ADDRESS Baltimore, Md. | | | |



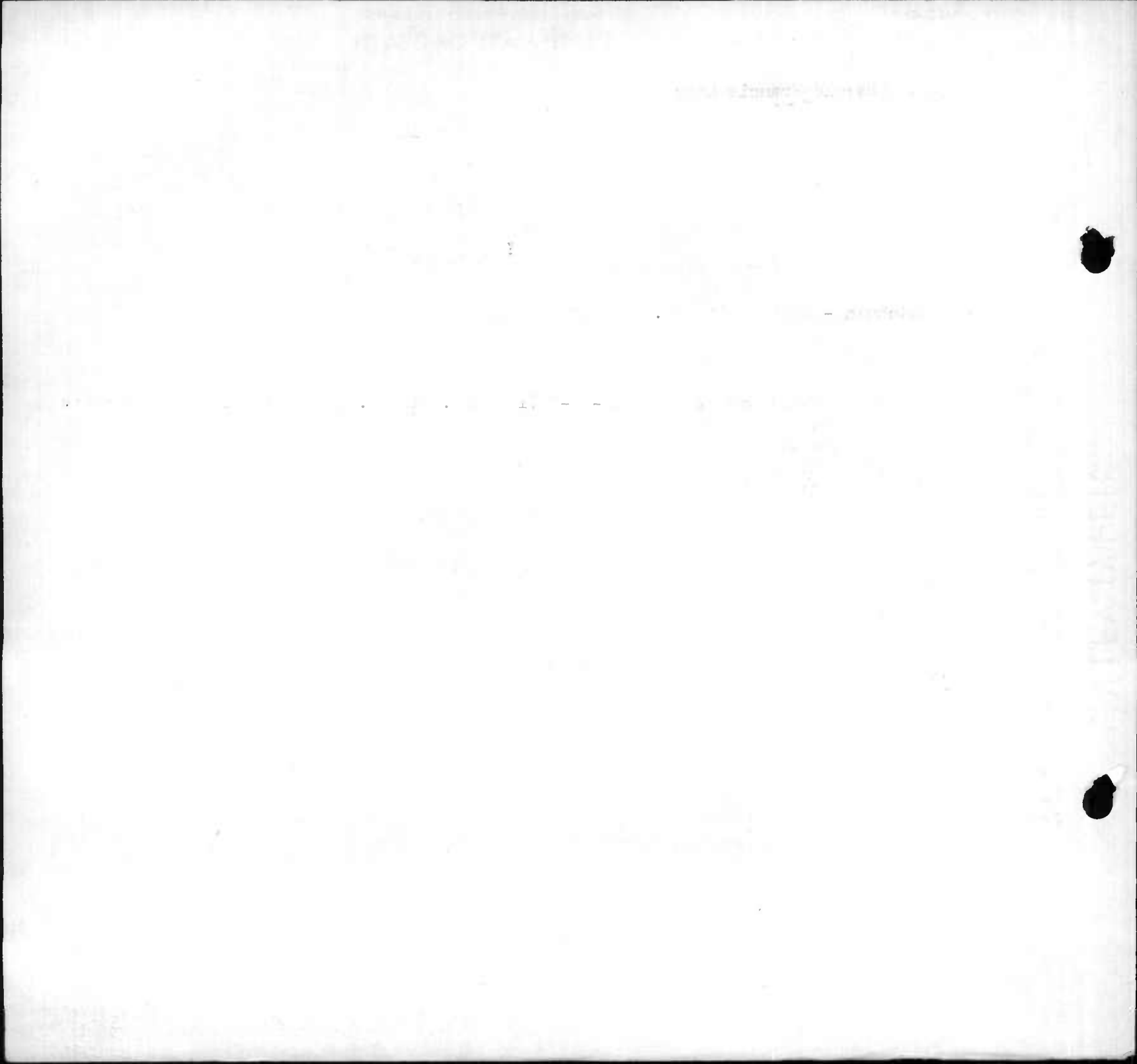
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200

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|--|--|---|--|--|--|
| BIRTH NO. 66 09177 | | CERTIFICATE OF DEATH | | Registered No. 66 09177 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Harold Francis Ross | | 2. DATE AND HOUR OF DEATH SEPTEMBER 10, 1966 4:50 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bon Secours Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 5-2-98 | | 9. AGE (In years last birthday) 68 | | 10. If Under 1 Yr. Months Days ; If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman - Davis Paint Co. | | 10B. KIND OF BUSINESS OR INDUSTRY Paint | | 11. BIRTHPLACE (State or foreign country) Chicago, Ill. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frank Ross | | 14. MOTHER'S MAIDEN NAME Agnes Wallace | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II | | 16. SOCIAL SECURITY NO. 212-18-2971 | | 17. INFORMANT ADDRESS Mrs. Mary B. Ross same address as above | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.0 I Perforation of Cecum due to closed loop obstruction - Ca. of Ascending Colon | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | 3 days | |
| | | (B) DUE TO | | MONTHS | |
| | | (C) DUE TO | | 3 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION Sept. 9/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Large bowel obstruction & perforation | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (H) (this hospital) attended the deceased from September 8, 1966 to Sept. 10, 1966 , that (H) (we) last saw the deceased alive on September 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE S. V. Gamboa | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. Bon Secours Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/1966 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Wm. J. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Baltimore north spa. rd. | | | |

SEP 12 1966



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 09178

BIRTH NO.

66 09178

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Frank J. Staska

2. DATE AND HOUR OF DEATH

7 September '66 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

708 North Bradford Street

21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-16-83

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Johns Hopkins Hosp.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Staska

14. MOTHER'S MAIDEN NAME

Katherine Unlir

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-30-6164

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Carcinoma of Prostate

1+ yrs.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

NONE

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/31/66 19 to 9/7/66 19
that (I) (we) last saw the deceased alive on 9/7/66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William A. Emerson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/7/66

23C. PHYSICIAN'S
NAME (Type)

William A. Emerson

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-10-66

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town or county)

Baltimore Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 12 1966

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Philip E. Czech 124 Chocoma Ave

ADDRESS

7 September 60

14-16-83

13-16-83

14

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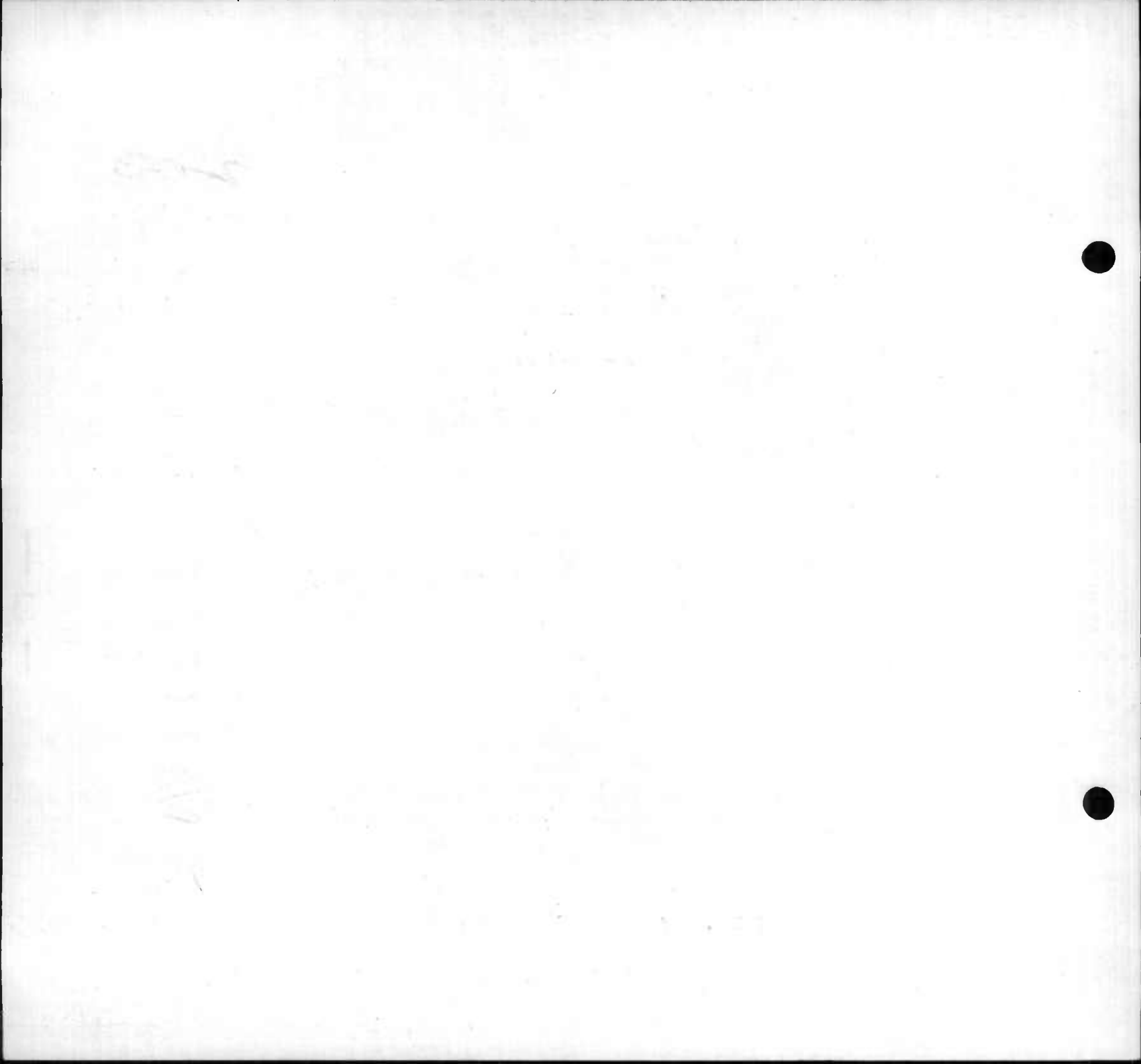
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4/2/60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--------------------------------------|--|---|
| BIRTH NO. 66 09179 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09179 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ramseyer, Sullivan B.</i> | | 2. DATE AND HOUR OF DEATH <i>9/7/66 4:50 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Montefello State Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 26-08</i> | |
| D. STREET ADDRESS (If rural, give location) <i>3720 Mt. Pleasant Ave.</i> | | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>5/29/1910</i> | 9. AGE (In years last birthday) <i>56</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry Worker Home Laundry</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home Laundry</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Charles Franklin</i> | | 14. MOTHER'S MAIDEN NAME <i>Virginia Brem</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>218-16-1909</i> | | 17. INFORMANT ADDRESS <i>Hospital Records</i> | |
| 18. <i>175.0 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Coronary Arteriosclerosis</i> <i>2 metastases</i> | | <i>3 years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0 1963</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, lawn, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/13/66</i> 19 to <i>9/7/66</i> 19 | | that (I) (we) last saw the deceased alive on <i>9/7/66</i> 19 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <i>Daniel G. Lai</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/7/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i> | | M.D. 23D. ADDRESS <i>2201 Argonne Drive, Baltimore 15, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sep 10, 1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Fork Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Fork, Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Philip J. Curren</i> | |
| | | | | ADDRESS <i>1211 Chesaer Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09180 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09180 | |
|--|------------------|---|----------------------------------|--|------------------------------|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) John J Melka | | | | 2. DATE AND HOUR OF DEATH Sept. 6, 1966 1 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 905 N. Patterson Park Ave. | | | | A. STATE Maryland. | | | |
| | | | | C. CITY OR TOWN Baltimore | | | |
| | | | | D. STREET ADDRESS 905 N. Patterson Park Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married. | 8. DATE OF BIRTH May 18, 1888 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY Smearina Tailors | | 11. BIRTHPLACE (State or foreign country) Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Vaclav Melka. | | | | 14. MOTHER'S MAIDEN NAME Mary Pasky | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-03-8494 | | 17. INFORMANT ADDRESS Frances Melka 905 N. Patterson Park Ave. | | | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Carcinoma of Prostate with Metastasis (B) Arterio Sclerosis Cardio-Vascular Disease (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 year Unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 5, 1966 to Sept 6, 1966 that (I) (we) last saw the deceased alive on July 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Philibert Artigiani | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 7/66 | |
| 23C. PHYSICIAN'S NAME (Type) Philibert Artigiani | | | | 23D. ADDRESS 2305 Mayfield Ave. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 10, 1966 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Philip E. Gach | | ADDRESS 1211 Chesaco Ave | |

July 1902

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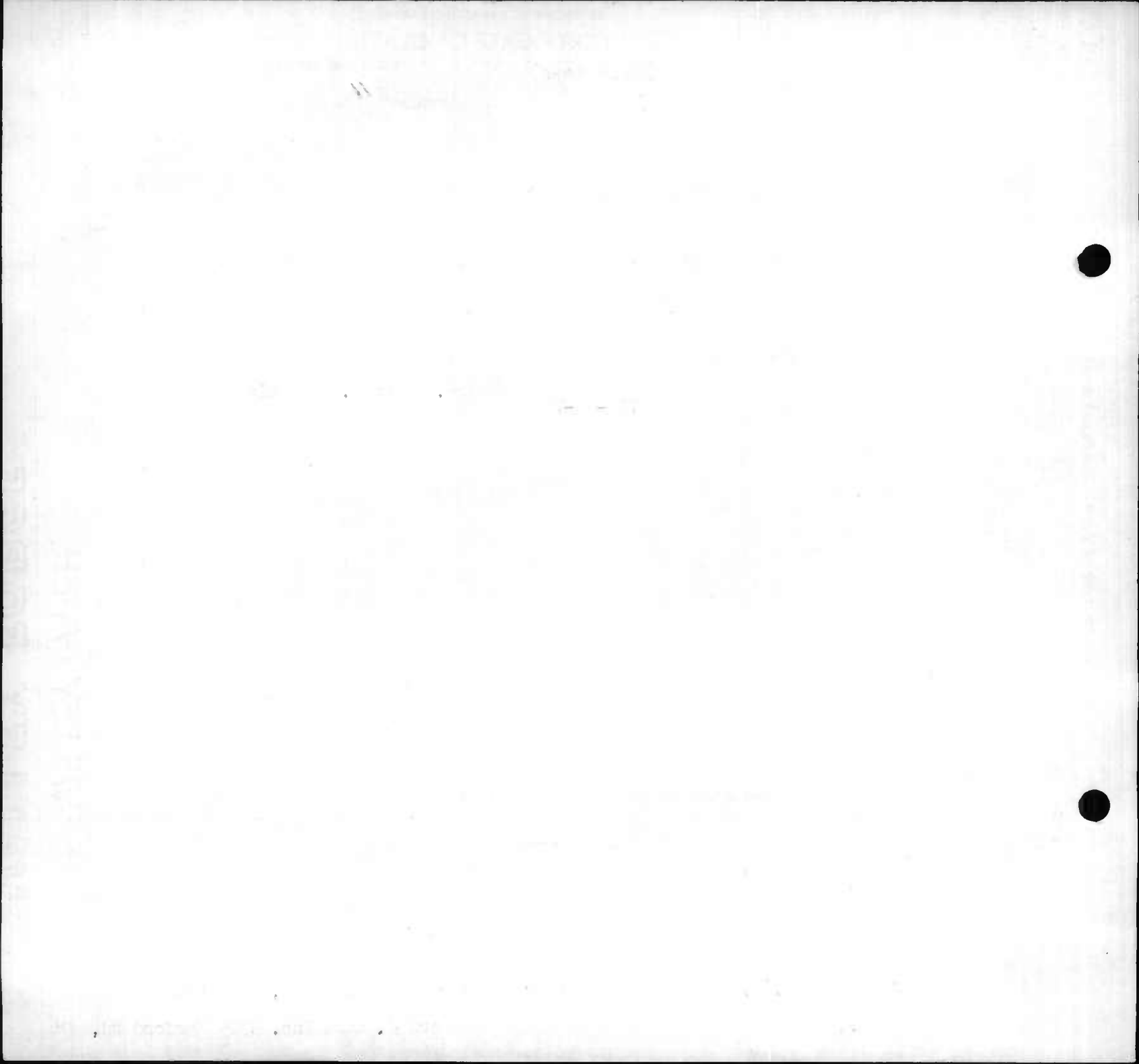
July 1902

July 1902

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|---|--|---|--|---|
| BIRTH NO. 66 09181 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09181 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) BACIGALUPA (BASS) Andrew Leo (Henry Bass) | | | 2. DATE AND HOUR OF DEATH 9/11/66 7:25 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY D. STREET ADDRESS (If rural, give location) 3802 Biddison Lane #6 | | |
| 5. SEX M | 6. RACE CAU. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/21/93 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOPER FOR R.R. | | 10B. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | 13. FATHER'S NAME Louis Bacigalupa | | |
| 14. MOTHER'S MAIDEN NAME Louise Cuneo | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I | | |
| 16. SOCIAL SECURITY NO. 717-07-7608 | | | 17. INFORMANT Mrs. Maria L. Bacigalupa ADDRESS Same | | |
| 18. I 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA OF COLON (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 mos. | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION July & Aug. 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of Colon | | 20A. AUTOPSY? (Yes or No) No. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/29 1966 to 9/11 1966, that (I) (we) last saw the deceased alive on 9/11 1966 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE Merwin L. Trail | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/11/66 |
| 23C. PHYSICIAN'S NAME (Type) MERWIN L. TRAIL | | | 23D. ADDRESS Church Home & Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Leonard J. Ruck Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. #14 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|---|--|--|--|
| BIRTH NO. 66 09182 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09182 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) JAMES NICHOLAS PISTOLAS | | | 2. DATE AND HOUR OF DEATH 9 10 66 8:45A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL WILKENS & CATON BALTO 29 MD 1208 DORAGEN COURT | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) LUTHERVILLE 53-00 | | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2 10 99 | 9. AGE (In years last birthday) 67 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY BAR | | 11. BIRTHPLACE (State or foreign country) GREECE | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME NICHOLAS Pistolas | | | 14. MOTHER'S MAIDEN NAME EVELYN MARMARY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST AGNES RECORDS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO Massive Gastrointestinal bleeding (B) DUE TO Severe Cholangitis (C) Pancreatic Abscess. | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) YES | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 7 28 1966 to 9 10 1966, that (X) (we) last saw the deceased alive on 9 10 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE Rolando Del Rosario | | | 23B. DATE SIGNED 9/10/66 | | |
| 23C. PHYSICIAN'S NAME (Type) ROLANDO DEL ROSARIO | | | 23D. ADDRESS ST AGNES HOSP. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery | |
| 24D. LOCATION (City, town, or county) Woodlawn, Md. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR R. E. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 09183 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | | 66 09183 | |
|--|---------|--|------------------|------------------------------------|---|--|---|---------------------------------|-------------------|--------------------------|---|
| 1. NAME OF DECEASED (Type or Print) | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| JOSEPH N. BEHR | | | | | | 9/9/66 1 3:35 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | | | |
| MERCY HOSPITAL INC. 37 | | | | | | 563 MARYLAND BALTO | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | Baltimore #14 | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | 5603 Birchwood Ave B 27-06 | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |
| M | W | Married | 11-12-1878 | 87 | Ret. MAIL CARRIER - Post Office | | MARYLAND | U S | CASPER BEHR | BARBARA WEINSTEIN | NO |
| 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | |
| | | | | | | 881 ANNA M. Behr SAME | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) Renal insufficiency | | | | | |
| ANTECEDENT CAUSES | | | | | | (B) Occlusion of renal artery | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (C) & Renal cell carcinoma | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | Atelactasis, due to stasis | | | | | |
| 19A. DATE OF OPERATION | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 2 | | | | | | | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| Yes | | | | | | Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | | |
| 21E. INJURY OCCURRED | | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/1/66 to 9/9/66, that (I) (we) last saw the deceased alive on Sep. 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | | | | | |
| Stephen J. Williams M.D. | | | | | | 9/9/66 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | | | |
| | | | | | | M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | | 24B. DATE | | | | | |
| Burial | | | | | | 9/13/66 | | | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Holy Redeemer Cem | | | | | | BALTIMORE, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | | 25B. NAME OF REGISTRAR | | | | | |
| Sep 12 1966 | | | | | | Robert E. Stokely | | | | | |
| 25C. FUNERAL DIRECTOR | | | | | | 25D. ADDRESS | | | | | |
| Leonard J. Buck, Inc. | | | | | | 5305 HARFORD Rd. | | | | | |

10-10-10

11-11-11

12-12-12

13-13-13

14-14-14

15-15-15

16-16-16

17-17-17

18-18-18

19-19-19

20-20-20

21-21-21

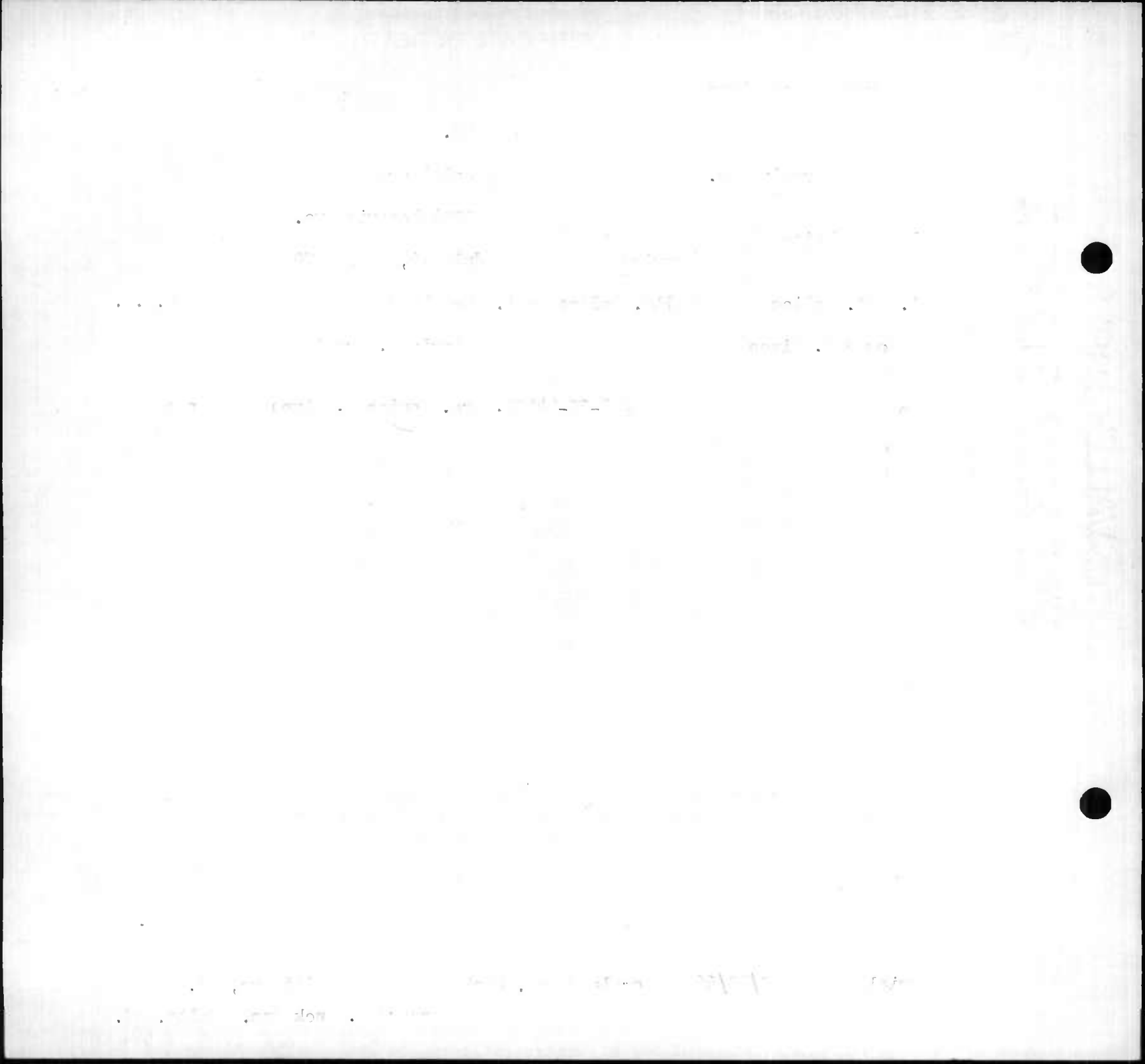
22-22-22

23-23-23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 66 09184 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09184 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George Luther Dixon | | | |
| 2. DATE AND HOUR OF DEATH Sept 10, 1966 11:10 a.m. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) 3304 Moravia Ave. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3304 Moravia Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH July 19, 1887 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sgt. Police | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Police Dept. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George W. Dixon | | 14. MOTHER'S MAIDEN NAME Maria E. Trott | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-30-4473A | | 17. INFORMANT Mrs. Louise H. Dixon ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Enterobacter C.V.D. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from July 1966 to Sept 10 1966 , that (I) (we) last saw the deceased alive on Sept 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Henry Haase | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED SEP 12 1966 | |
| 23C. PHYSICIAN'S NAME (Type) J. Henry Haase M.D. | | 23D. ADDRESS 2926 E. L. 10 Springhouse Bldg. 18th Fl. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto. Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|---|-------------------------------------|--|---|
| BIRTH NO. 66 09185 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09185 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jack Jethro Ingram | | 2. DATE AND HOUR OF DEATH 9-9-66 8 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 52-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | D. STREET ADDRESS (If rural, give location) 105 Bliss Lane | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 11-18-25 | 9. AGE (In years lost birthday) 40 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 10B. KIND OF BUSINESS OR INDUSTRY Westinghouse | | 11. BIRTHPLACE (State or foreign country) Kentucky | |
| 13. FATHER'S NAME Monty Ingram | | 14. MOTHER'S MAIDEN NAME Pearl Holcomb | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II | | 16. SOCIAL SECURITY NO. 404-26-3029 | | 17. INFORMANT (Wife) ADDRESS MRS Frances L. Ingram Same as #4 | |
| 18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hodgkin's Lymphoma | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30- 19 66 to 9-9 19 66 . that (I) (we) last saw the deceased alive on 9-9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE B. Portney | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-9-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-13-66 | | 24C. NAME OF CEMETERY or CREMATORY Balta National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR E.B. Fleming Bingherton Funeral Home Glen Burnie, Md | | | |

WASH. STATE
HOSPITAL
11-18-32 40

UNIVERSITY HOSPITAL
WASH. STATE
11-18-32 40

Hobbs's Lymphoma

NO

NINE

UNIVERSITY HOSPITAL

11-18-32

32-30-16 1B

C-456 66 09186

BALTIMORE CITY HEALTH DEPARTMENT

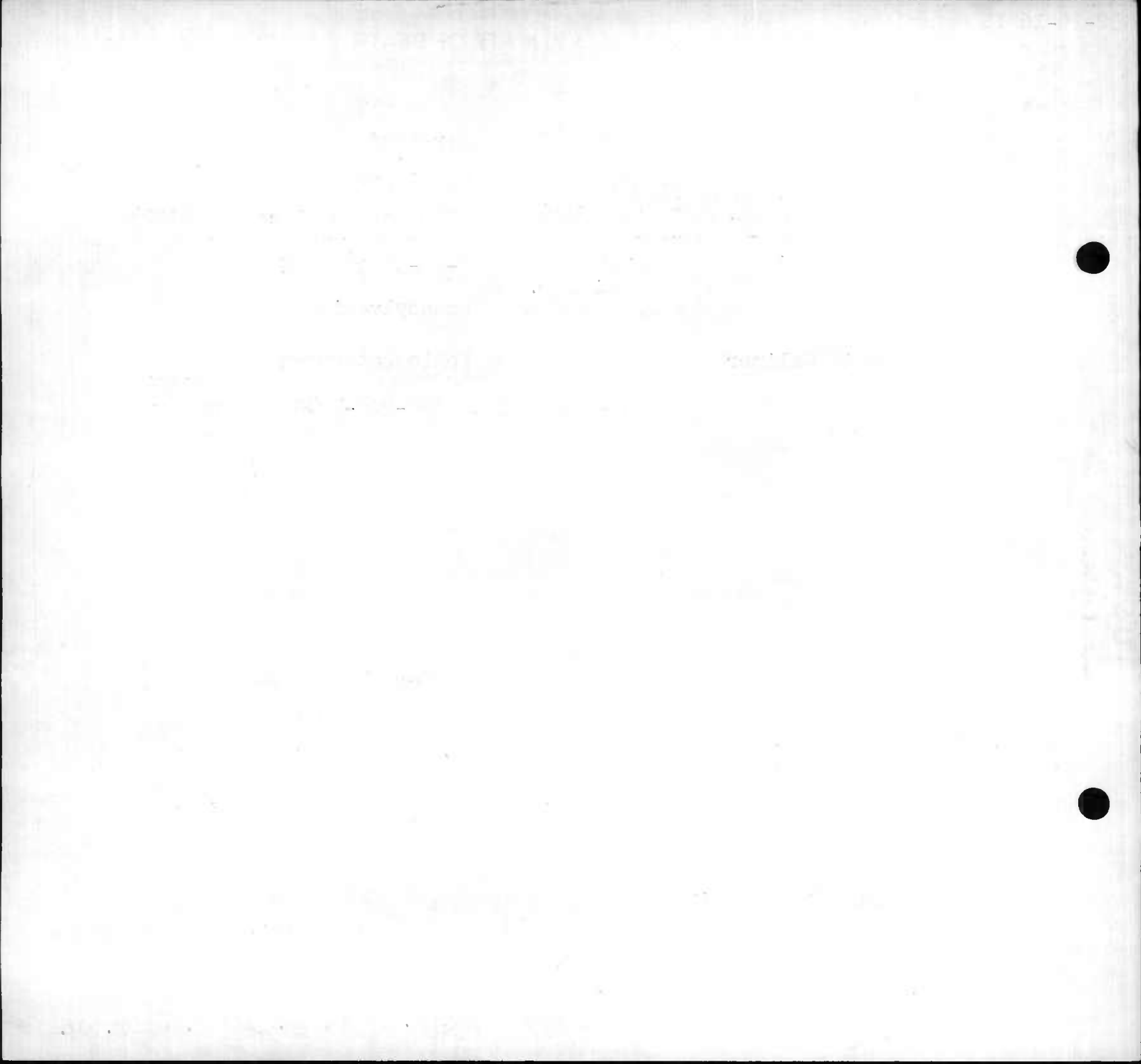
CERTIFICATE OF DEATH

Registered No. 66 09186

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|---|-------------------------------|--|--|
| BIRTH NO. 66 09186 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09186 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. 66 09186 | |
| 1. NAME OF DECEASED (Type or Print) CALIMER GEORGE | | 2. DATE AND HOUR OF DEATH 9/10/66 11:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3219 Esther Place #21224 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8-22-2488 | 9. AGE (In years last birthday) 78 | 10. If Under 1 Yr. Months Days II Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pile Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Raymond Concrete | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Noah Calimer | | 14. MOTHER'S MAIDEN NAME Belle Patterson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI | | 16. SOCIAL SECURITY NO. 212-01-6672A | | 17. INFORMANT #21224 ADDRESS RECORDS-BCH-4940 Eastern Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 177X I CAUSE OF DEATH Wide Spread metastatic Adeno carcinoma of Prostate 3 years | | INTERVAL BETWEEN ONSET AND DEATH 3 years | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/9/66 19 to 9/10/66 19 that (I) (we) last saw the deceased alive on 9/10/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pablo T. Trepo | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) PABLO TREPO | | M.D. 23D. ADDRESS BCH 4940 Eastern Avenue | | #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. F. F. | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. | | | |



1
B-620

66 09187

BALTIMORE CITY HEALTH DEPARTMENT

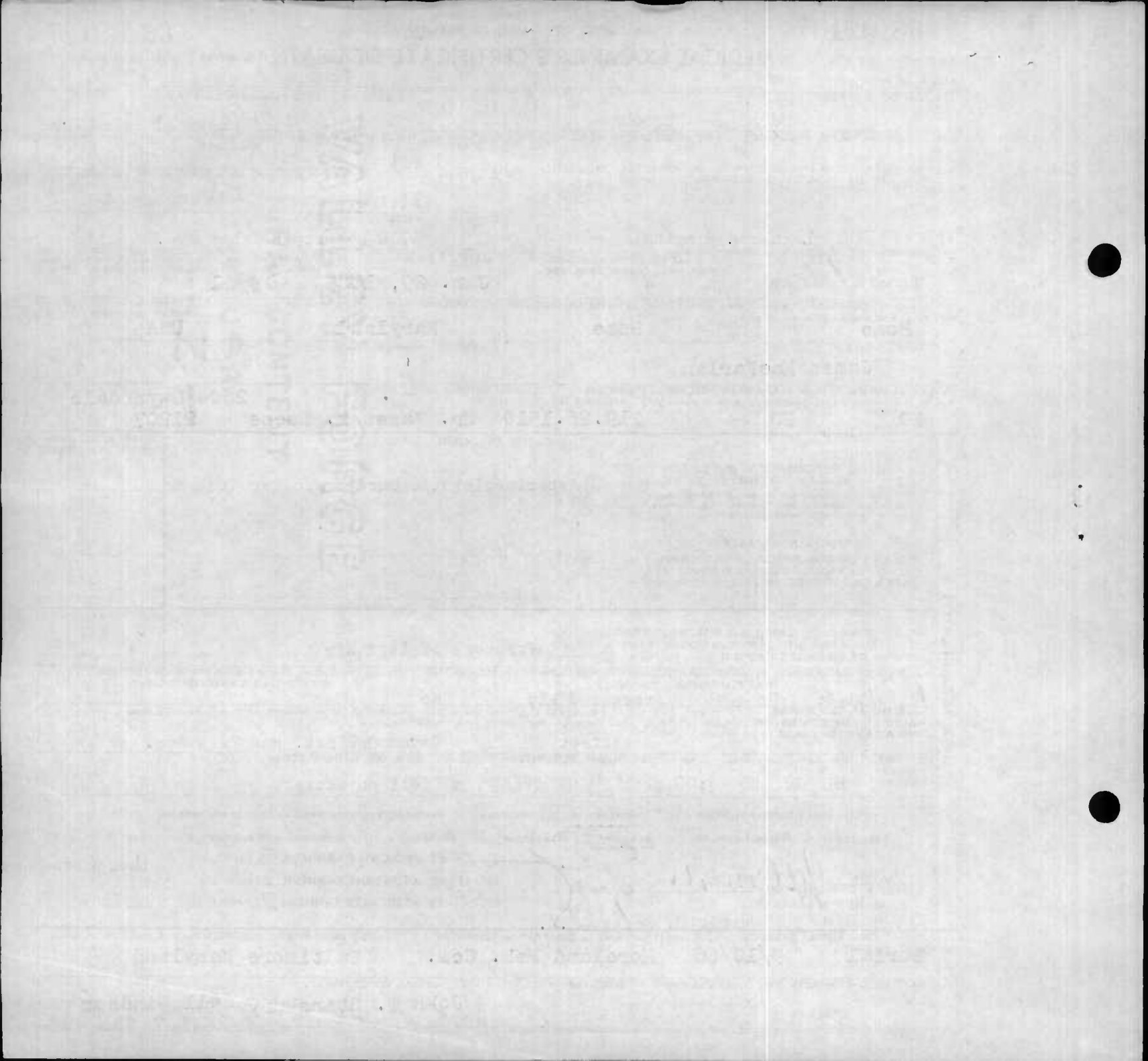
66 09187

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

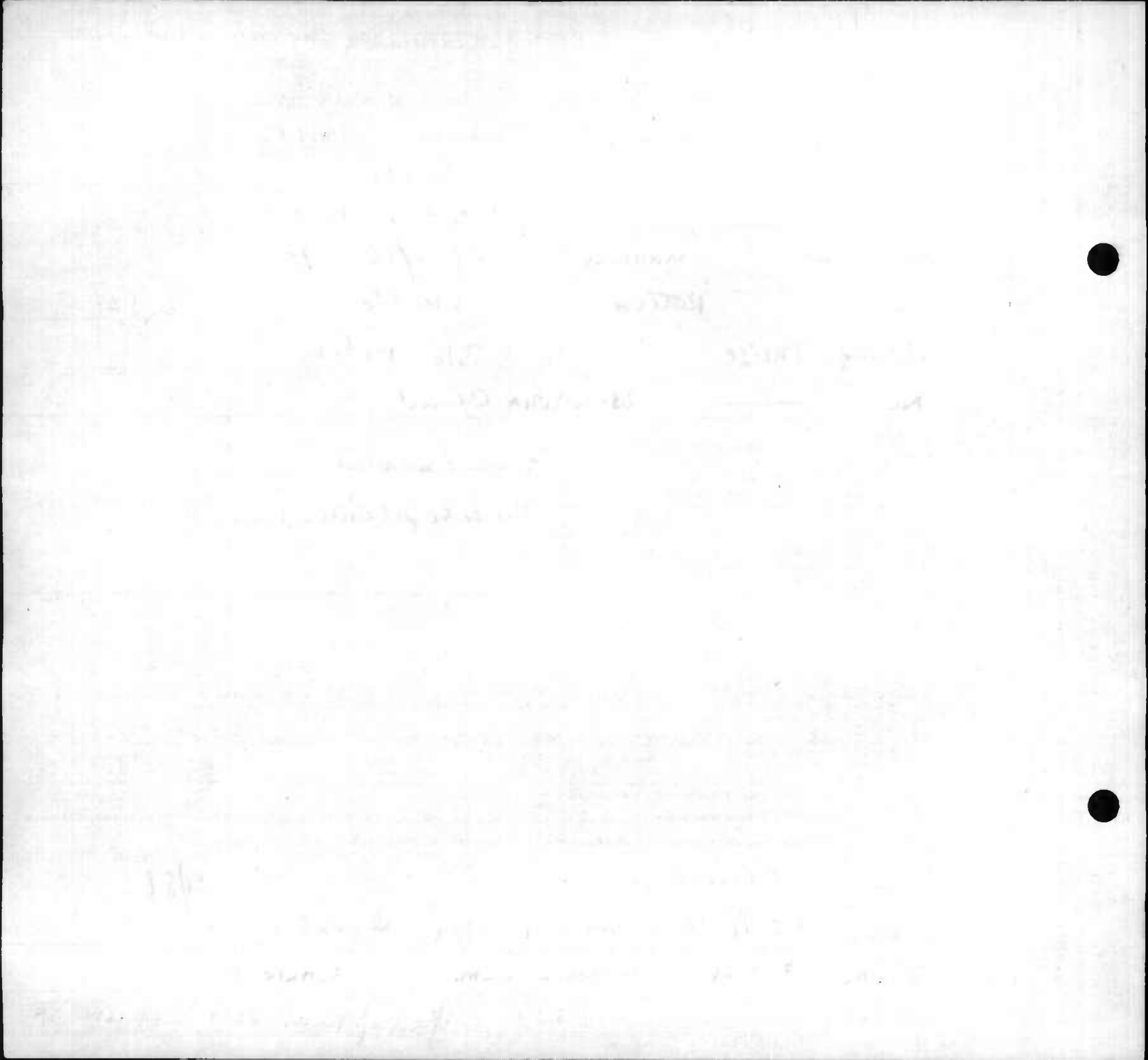
| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Jean Brooks | | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/8/66 12:20 p.m. | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 46 Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 28-41 D. STREET ADDRESS (If rural, give location) 4730 Liberty Heights Ave. | | | | | | | | | |
| 5. SEX female | | 6. RACE white | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | | 8. DATE OF BIRTH Jan. 29, 1885 | | 9. AGE (In years last birthday) 80 31 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James MacFarlan | | | | 14. MOTHER'S MAIDEN NAME L | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO NO | | | | 16. SOCIAL SECURITY NO. 219.26.1510 | | 17. INFORMANT Mr. James M. Reese ADDRESS 2604 Gwynndale 21207 | | | | | | | |
| 18. CAUSE OF DEATH 42214 E 1703.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (A) _____ (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of left hip | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 8/31/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fractured hip | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Gwynn Oak Ave. and Main Ave. 28-02 | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) 8 27 66 3:00 | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell on street | | | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/9/66 | | | | | | | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/10/66 | | 23C. NAME of CEMETERY or CREMATORY Moreland Mem. Hem. | | | | 23D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | | | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 24B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 24C. FUNERAL DIRECTOR John T. Stansbury | | | | ADDRESS 6411 Windsor | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

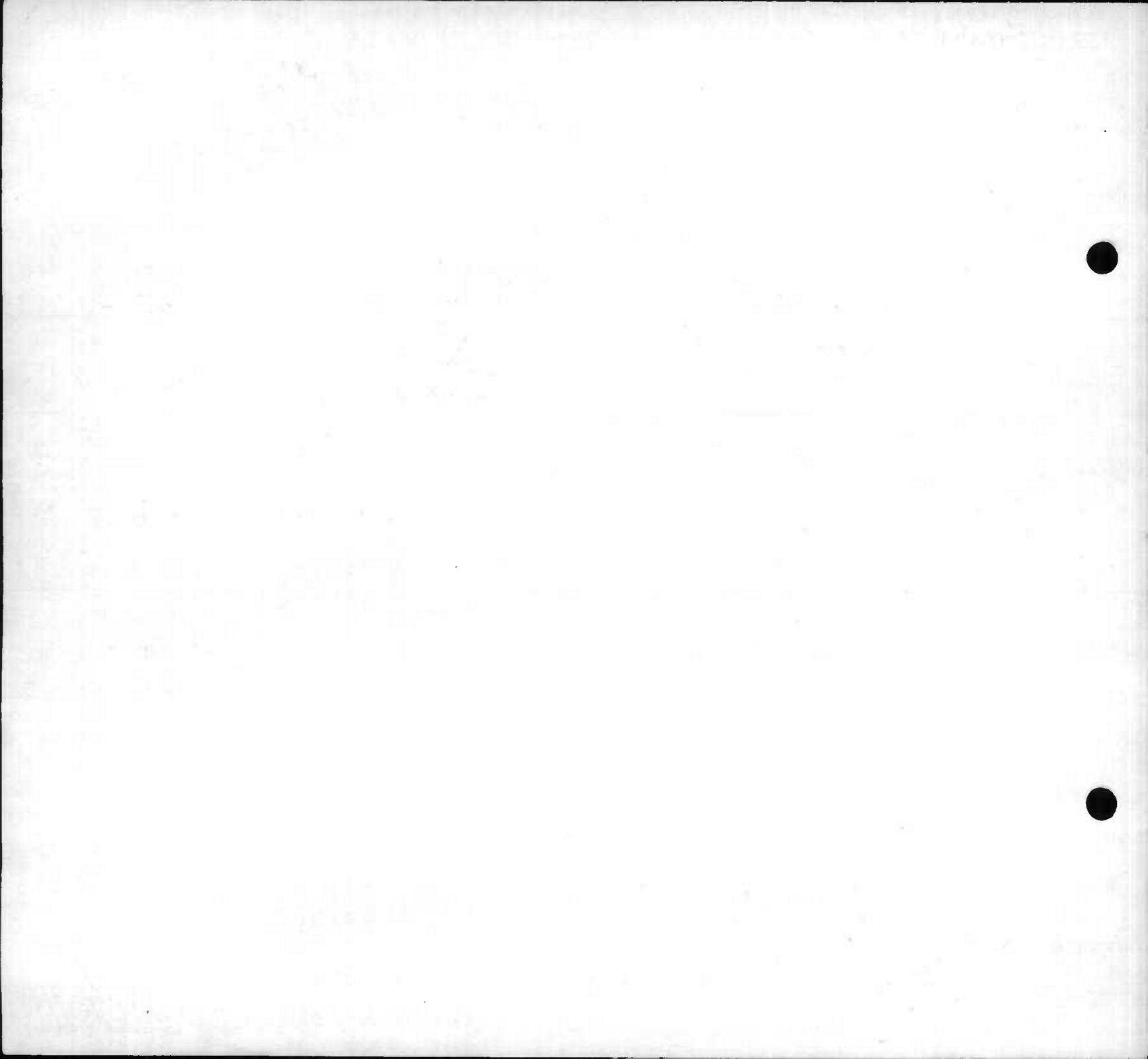
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09188</u> | |
|--|---------------------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 09188</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Richard W Meise</u> | | | 2. DATE AND HOUR OF DEATH <u>9-8-66</u> <u>13:30</u> <u>W</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u> D. STREET ADDRESS (If rural, give location) <u>533 N Kenwood Ave</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>2/22/16</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO</u> | |
| 13. FATHER'S NAME <u>HENRY Meise</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ida Fitch</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-36-8691A</u> | | 17. INFORMANT <u>Chart</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>464 XI</u> <u>Pulmonary embolism</u> <u>Thrombo phlebotic disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Daniel C. Wilkerson</u> M.D. | | | | 23B. DATE SIGNED <u>9/8/66</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Daniel C. Wilkerson</u> | | | | 23D. ADDRESS <u>421 Regester Ave.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-12-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD CEM.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fadden</u> | | 25C. FUNERAL DIRECTOR <u>Harley Miller - 2334 Jefferson St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

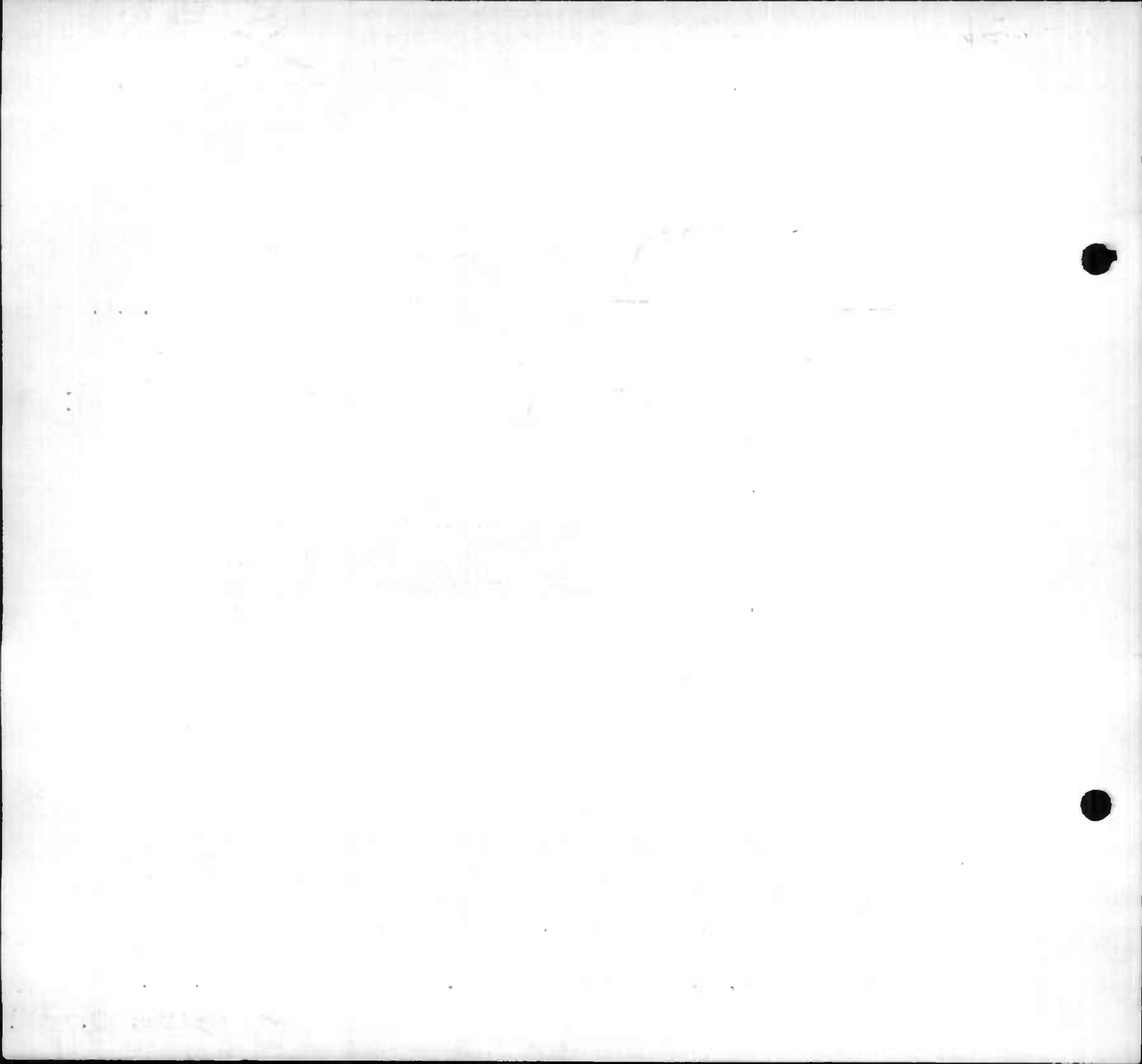
| BIRTH NO. 66 09189 | | | | BALTIMORE CITY HEALTH DEPT. | | CERTIFICATE OF DEATH | | Registered No. 66 09189 | |
|---|---------------------|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) CLARK, VIOLA | | | | 2. DATE AND HOUR OF DEATH 9/5/66 1335 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MD | | B. COUNTY Howard | | | |
| 38 UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Jessup, Md. 63-00 | | | | | |
| D. STREET ADDRESS (If rural, give location) Box 180-C | | | | | | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 5.6.08 | | 9. AGE (In years last birthday) 58 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME Frank Clark | | | | 14. MOTHER'S MAIDEN NAME Eliza ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Rosalie Anderson | | ADDRESS item # 4 | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH PULMONARY EMBOLUS (A) DUE TO CONGESTIVE HEART FAILURE (B) HYPERTENSION, ESSENTIAL? DUE TO (C) DIABETES MELLITUS | | | | INTERVAL BETWEEN ONSET AND DEATH 4-mo 5 yrs 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on 9/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Kurt P. Sligar | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/5/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) KURT P. SLIGAR | | | | 23D. ADDRESS M.D. UNIVERSITY HOSPITAL, BALTO., MD | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/10/66 | | 24C. NAME OF CEMETERY or CREMATORY 1st Baptist Church Cem. | | 24D. LOCATION (City, town, or county) (State) Guyton Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR Robert E. Talano | | 25C. FUNERAL DIRECTOR ADDRESS Robert L. Snowden Rockville, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|-----------------------------|--------------------------------------|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09190 | | | | |
| BIRTH NO. 61-20716 66 09190 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) ALAN D. MARSHALL | | | | | 2. DATE AND HOUR OF DEATH 9-8-66 10.15 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | | | | A. STATE B. COUNTY MARYLAND BALTIMORE | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) REISTERSTOWN 53-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 6 SUNNY KING DRIVE | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH 7-16-61 | 9. AGE (In years last birthday) 5 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---- | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME ANTHONY M. MARSHALL | | | | | 14. MOTHER'S MAIDEN NAME MAXINE CHESTER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. None | | | | |
| | | | | | 17. INFORMANT Anthony Marshall 6 Sunny King Dr. Reisterstown Md. | | | | |
| | | | | | ADDRESS | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 18. 754.51 Cardiac Arrhythmia Congestive Heart Failure Congenital Heart Disease Thrombosis Pulmonary & Multiple Cong Anomalies | | | | | | | | | |
| 19A. DATE OF OPERATION 9/2/66 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Marked Cancer | | | | |
| 20A. AUTOPSY? (Yes or No) NO | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30 19 66 to 9/8 19 66 that (I) (we) last saw the deceased alive on 9/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Julius F. Booker Jr. | | | | | 23B. DATE SIGNED 9/8/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) JULIUS F. BOOKER, JR. M.D. | | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE Sept. 12, 1966 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY Evergreen Mem. Gardens | | | | | 24D. LOCATION (City, town, or county) (State) Finksburg, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | | | 25B. NAME OF REGISTRAR R. E. Fairbank | | | | |
| | | | | | 25C. FUNERAL DIRECTOR Owings Mills, Md. | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|--------------------------------|
| 66 09191 | | CERTIFICATE OF DEATH | | 66 09191 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Francis A. Yarrish Frank XXXXXXXXXX | | Sept. 8, 1966 9:45 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Union Memorial Hospital | | Md. Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3619 Falls Rd. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| M | W | Never Married | 2/1/99 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Painter | | Appliance Mfg. | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George L. Yarrish | | Evelyn Webster | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 220-01-2087 | | Charles Yarrish | |
| 18. CAUSE OF DEATH | | ADDRESS | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 856 W 37th St. | | 10 days | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Baltimore Md. | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Malnutrition | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (H) (this hospital) attended the deceased from Sept. 1 1966 to Sept 8 1966, that (H) (we) lost saw the deceased alive on Sept 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| NAT E. Watson, Jr. | | | | Sept 8, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| NAT E. WATSON, JR. | | THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-12-66 | | Holy Redeemer Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 12 1966 | | John E. Taylor | | Ellsworth Imacost | |
| | | | | ADDRESS | |
| | | | | 4600 Liberty Hghts. Ave. | |

George L. Jones
Officer

George L. Jones

Officer

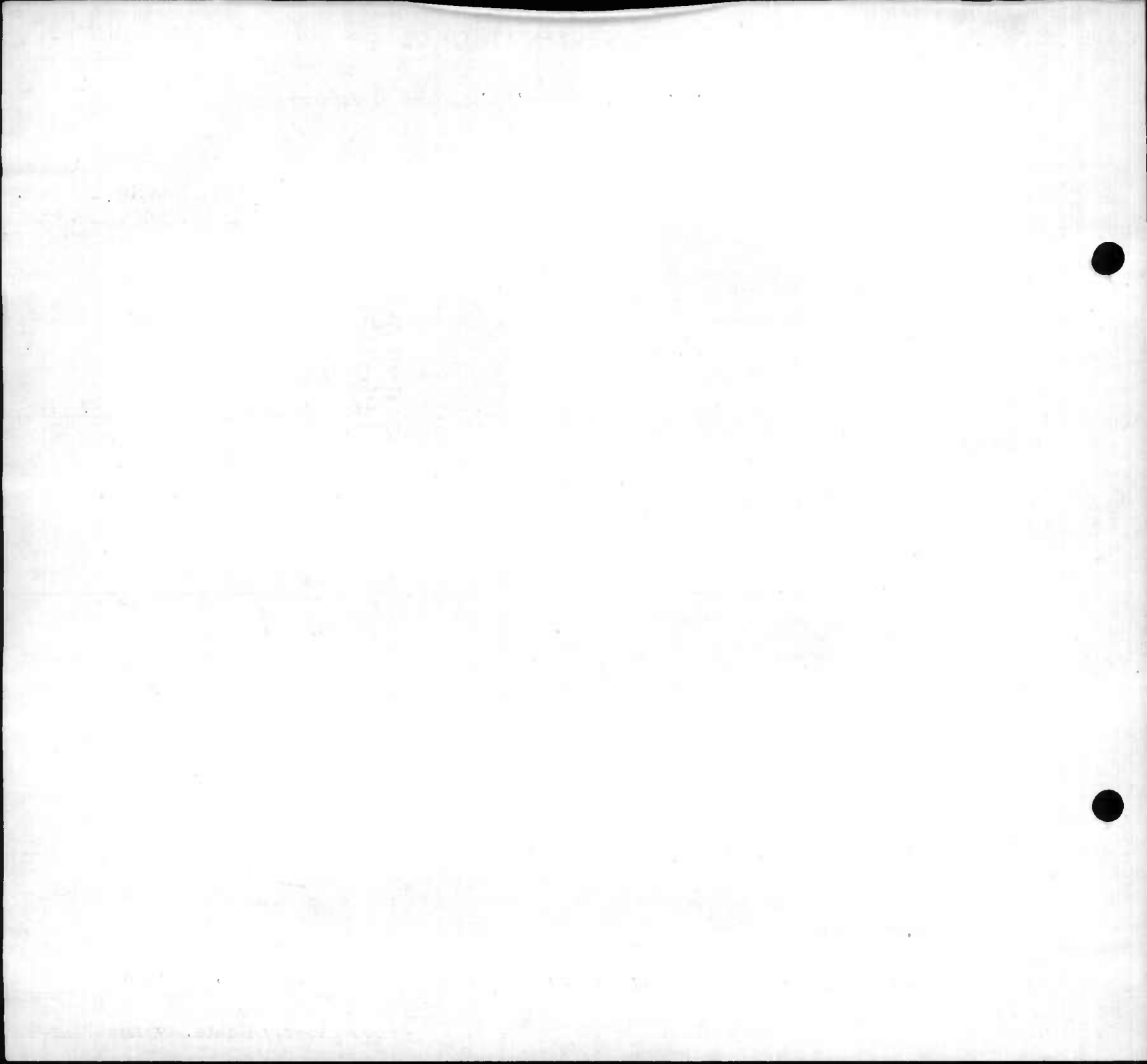
THE B. & O. R. R.

THE B. & O. R. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 66 09192 | | | | | Registered No. | | 66 09192 | | |
| BIRTH NO. 66 09192 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>William J. T. French, Jr.</i> | | | | | 2. DATE AND HOUR OF DEATH <i>9/11/66</i> <i>5 P</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | | | | A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>4013 Buckingham Rd.</i> | | | | |
| | | | | | | | | | |
| 5. SEX <i>Male</i> | | 6. RACE <i>Caucasian</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | | 8. DATE OF BIRTH <i>10/3/13</i> | | 9. AGE (In years last birthday) <i>52</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>William French</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Irene Peach</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT <i>Mrs. J. Davis</i> ADDRESS <i>4013 Buckingham Rd. Balt. Md.</i> | | |
| 18. <i>433.01-190.9</i> | | | | | CAUSE OF DEATH <i>Unknown</i> | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) <i>Cardiac Arrest</i> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>7/1 27/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Excision-nude Melanoma</i> | | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) — | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) — | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | | |
| 21D. TIME OF INJURY (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? — | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/10</i> 19 <i>66</i> to <i>9/11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/11</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>B. Ann Ward</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>9/11/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>B. Ann Ward</i> | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-15-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Family Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Randallstown, Maryland</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | | 25C. FUNERAL DIRECTOR <i>Elsworth Anacost</i> ADDRESS <i>4600 Liberty Hgts. Avenue</i> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

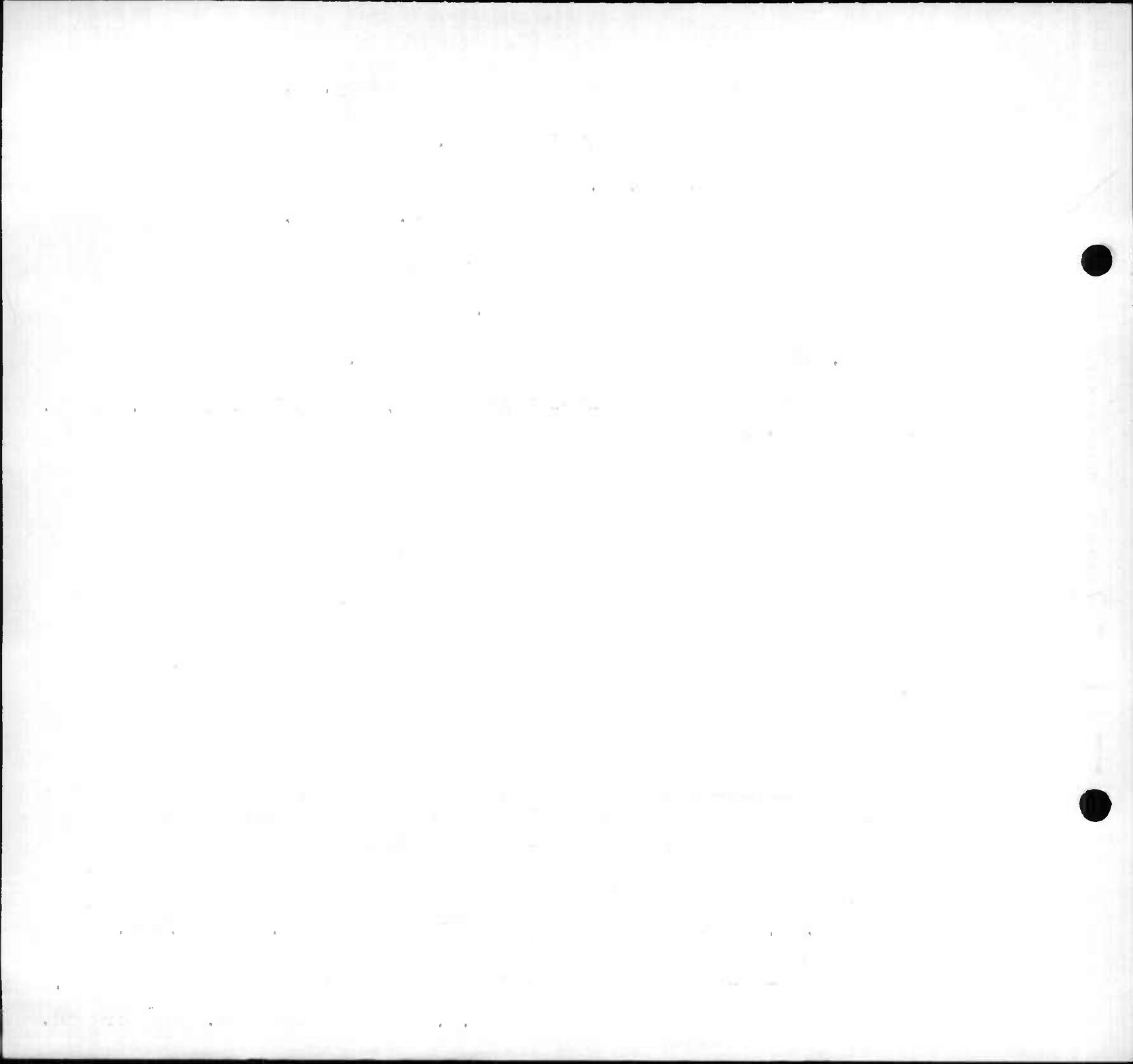
| | | | | | |
|---|-----------------------------|--|--|---|--|
| BIRTH NO. 66 09193 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09193 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>MRS MARY Jane GRADY</i> | | | 2. DATE AND HOUR OF DEATH <i>9-9-1966 11:45 PM</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS HOSPITAL</i> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. Md.</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>25-31</i> | | |
| 5. SEX <i>Fe</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) | 8. DATE OF BIRTH <i>8/2/93</i> | 9. AGE (In years lost birthday) <i>73</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Advertising Solicitor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>News Paper</i> | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>John Uhler Lemmon</i> | | | 14. MOTHER'S MAIDEN NAME <i>Agnes J. Hanafin</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>212-03-8002</i> | 17. INFORMANT ADDRESS <i>William M. Grady, 5037 Frederick Ave.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osthenio, etc. It means the disease injury or complication which caused death.) <i>Fractured Hip.</i> | | | CAUSE OF DEATH (A) DUE TO <i>Hypertensive Cardiovascular d. many years</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | (C) |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | FRACTURE OF LEFT HIP | | |
| 19A. DATE OF OPERATION <i>9-9-66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fractured Hip</i> | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>Med Exam notified</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>5037 Frederick Ave</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>9 6 1966 AM</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>fell coming out of bathroom.</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-9-66</i> to <i>9-9-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>W. K. Wiedmann</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-9-66</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>WILFRED K. WIEDMANN</i> | | | 23D. ADDRESS <i>715 PARK AVE</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>9/13/66</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. Fink</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>6 Vernon Lemmon 4611 Park Heights Ave.</i> | |

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FUNERAL DIRECTOR: IMPORTANT

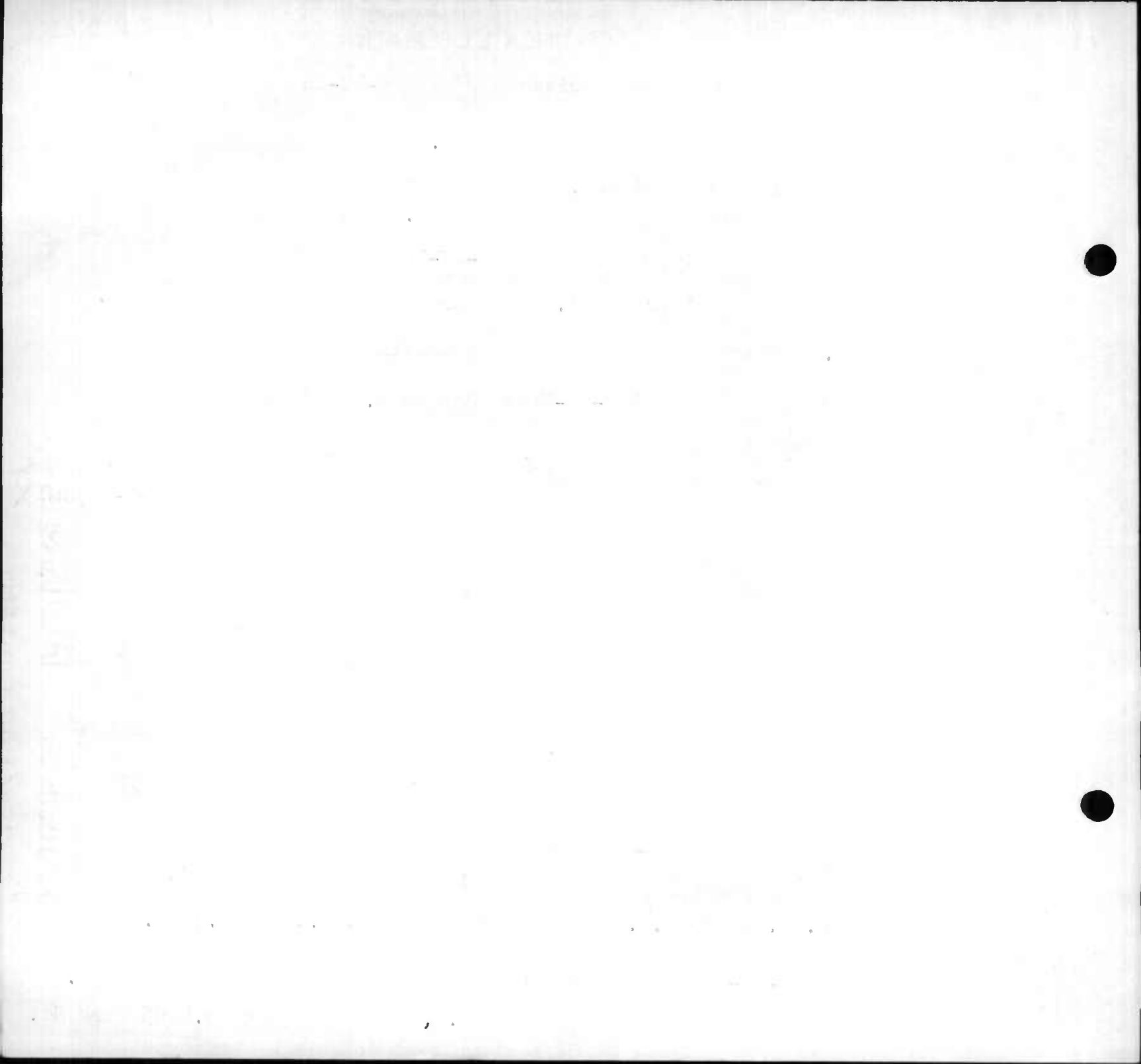
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|--------------------------------------|--|--|---|---|--|
| BIRTH NO. 66 09194 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 09194 | |
| 1. NAME OF DECEASED (Type or Print) Ernest Emil Bentz | | | | | 2. DATE AND HOUR OF DEATH Sept. 9, 1966 2:20 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens N. H. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 347 E. 29th St. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 4-10-1895 | 9. AGE (In years last birthday) 71 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Carl G. Bentz | | | | | 14. MOTHER'S MAIDEN NAME Amelia D. Goetz | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW1 | | | | | 16. SOCIAL SECURITY NO. 213-30-6131 | | 17. INFORMANT ADDRESS Robert G. Koch 3913 Ednor Rd., Balto. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH Several Years | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Carcinoma of Prostate | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1 19 66 to Sept. 9 19 66 , that (I) (we) last saw the deceased alive on Sept. 8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE L. M. Zimmerman | | | | | 23B. DATE SIGNED 9/12/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) L. M. Zimmerman | | | | | 23D. ADDRESS 3202 Harford Rd., Balto., Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9-13-66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | | 25B. NAME OF REGISTRAR Philip E. Jenkins | | | 25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09195 | |
|---|---|--|---|--|--|
| 66 09195 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | Patrick Allison Morison | | 2. DATE AND HOUR OF DEATH 9-10-66 8:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 218 Ridgewood Road Inc. 90 Gaddis Care Home | | (If not in hospital or institution, give street address or location) | | Md. Balto | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) | | 5 St. Dunstons Garth | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7-22-1889 | 9. AGE (In years lost birthday) 77 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY State of Md. | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Ernest N. Morison | | 14. MOTHER'S MAIDEN NAME Pricilla White | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 220-36-7607 | 17. INFORMANT Robert B. Morison | | ADDRESS Above |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Congestive Heart Failure (B) DUE TO Arterio-sclerosis (C) DUE TO Myocarditis | | INTERVAL BETWEEN ONSET AND DEATH 1-2 wks Gradual exit | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1955 to Sept 10 1966. that (I) (we) last saw the deceased alive on Sept 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. H. Woody M.D. | | M.D. | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED Sept 12-66 | |
| 23C. PHYSICIAN'S NAME (Type) W. H. Woody M.D. | | 23D. ADDRESS 1403 Park Ave., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-13-66 | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge | 24D. LOCATION (City, town, or county) (State) Pikesville Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | 25B. NAME OF REGISTRAR Robert E. Farley | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09196 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09196 | |
|---|---------------------|--|-------------------------------------|---|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ada Evans</i> | | 2. DATE AND HOUR OF DEATH <i>9/8/66</i> <i>4:50 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland Geriatric Hosp</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>4303 Marble Hall Road</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>12/13/83</i> | 9. AGE (In years last birthday) <i>82</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Md</i> | |
| 13. FATHER'S NAME <i>James Attig</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes-no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>214-20-0542</i> | | 17. INFORMANT <i>Chart</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>4221 I</i> | | CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardiovascular and Cerebrovascular disease</i> (B) DUE TO <i>Cerebrovascular disease</i> (C) <i>Myocardial infarction, secondary medium and tertiary vessels.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 PM - 4:50 PM</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> 19 <i>66</i> to <i>9/8</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/8</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel Wilkerson</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/8/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel Wilkerson</i> | | 23D. ADDRESS <i>Md. General Hosp. 421 Regester Ave. Balto. Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/12/1966</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i> | |
| | | 24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Balto. Co., Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 12 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>H. W. Jenkins & Sons Co. 4905 York Rd Baltimore 12, Md.</i> | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 09197</u> | |
|--|-----------------------------|--|------------------------------------|--|--|--|--|
| BIRTH NO. <u>66 09197</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>RALPH MCKENZIE WILLIAMS</u> | | 2. DATE AND HOUR OF DEATH <u>SEPTEMBER 9, 1966 10³⁵ A.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>108 W. UNIVERSITY PKWY.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED WIDOWED <u>M</u> DIVORCED (specify) | 8. DATE OF BIRTH <u>7/16/98</u> | 9. AGE (In years last birthday) <u>73</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>DR. ABRAM WILLIAMS</u> | | 14. MOTHER'S MAIDEN NAME <u>FRANCES (UNKNOWN)</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES UNKNOWN W.W.I</u> | | 16. SOCIAL SECURITY NO. <u>215-03-7533</u> | | 17. INFORMANT <u>BLANCHE T. WILLIAMS ABOVE</u> | | | |
| 18. <u>540.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEMATEMESIS & PERFORATION</u> <u>GASTRIC ULCER</u> | | CAUSE OF DEATH (A) <u>HEMATEMESIS & PERFORATION</u> (B) <u>GASTRIC ULCER</u> (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS</u> | |
| 19A. DATE OF OPERATION <u>8/3/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SIGMOID COLON</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>PERFORATION</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>PERFORATION</u> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 18</u> 19 <u>66</u> to <u>SEPTEMBER 9</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>SEPTEMBER 9</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Charles E. Boring Jr.</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Sept 9, 1966</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>CHARLES E. BORING, JR.</u> | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-12-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u> | | 24D. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd.</u> | | | |

RECEIVED SEPTEMBER 11 1952

MARYLAND

BALTIMORE

108 W UNIVERSITY PKWY

7/10/52

MARYLAND

FRANCIS

CHART

UNION MEMORIAL HOSPITAL

M. GOODMAN

DR. ABRAHAM WILLIAMS

UNKNOWN

9/2/52

RECEIVED SEPTEMBER 18 1952

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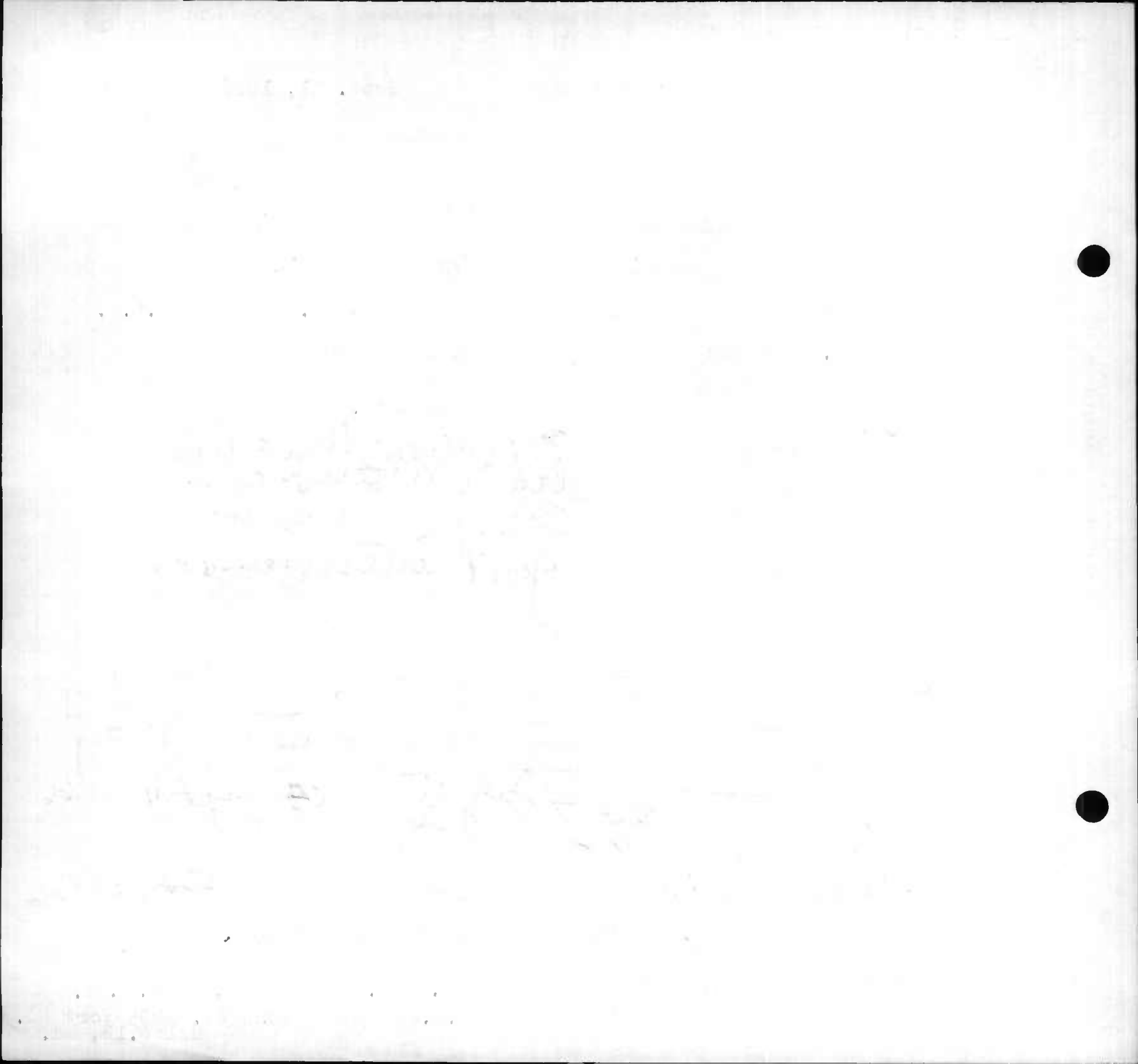
Charles E. Bond Jr.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 09198 | |
|---|---------------------|---|--------------------------------------|--|--|--|--|
| BIRTH NO. 66 09198 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Edith Jane Wiegand | | 2. DATE AND HOUR OF DEATH Sept. 11, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5912 Ayleshire Road | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12 D. STREET ADDRESS (If rural, give location) 5912 Ayleshire Road | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/23/1894 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas J. Robinson | | | | 14. MOTHER'S MAIDEN NAME Molly Taylor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT William D. Wiegand | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Infarction Myocardium due to arteriosclerosis Coronary Thrombus gent arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15 19 66 to Sept 11 19 66 , that (I) (we) last saw the deceased alive on Sept 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald W. Mintzer | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 12/1966 | |
| 23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer | | | | 23D. ADDRESS 3009 Evergreen Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/1966 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Brds. | | 24D. LOCATION (City, town, or county) (State) Timonium, Balto. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR John E. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto. 12, Md. | | | |



1
S-552

66 09199

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09199

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|---|-------------------------|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) Eleanor V. Smink | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/8/66 5:05 p. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospitals | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5300 D. STREET ADDRESS (If rural, give location) 6805 Roberts Ave. | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH March 8-1922 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Edward & Anthony | 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Stella Kravutski | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 187-18-2465 | 17. INFORMANT ADDRESS | | |

| | | | | | |
|-----------------------|---|--|---|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH 416X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rheumatic heart disease (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| | 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| | ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/9/66 | | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 9-12-66 | 23C. NAME OF CEMETERY or CREMATORY Garden of Faith | 23D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| | 24A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | 24B. NAME OF REGISTRAR Robert E. Taylor | 24C. FUNERAL DIRECTOR ADDRESS Walter Dabrowski 1005 Dunderberg Ave. | | |

VALLEY GORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|--|--|
| BIRTH NO. 66 09200 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09200 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>BANDZKOLEK, Mrs Stella</i> | | | 2. DATE AND HOUR OF DEATH <i>9/11/66 at 6:45 a.m.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Church Home & Hospital</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | D. STREET ADDRESS (If rural, give location) <i>1940 Wareham Rd (22)</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>2/8/2</i> | 9. AGE (In years last birthday) <i>64</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | 13. FATHER'S NAME <i>Vincent Janblowski</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Unknown MARY MAKAREWICZ</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT ADDRESS <i>CASIMIR BANDZKOLEK 1940 WAREHAM RD</i> | | | |
| 18. <i>153.8</i> I <i>216-09-4557A</i> CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Peritonitis. Small Bowel Fistula.</i> | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Carcinoma of the right colon</i> | | (B) DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>18/14/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca of right colon</i> | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>August 5</i> 19 <i>66</i> to <i>Sept. 11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>September 10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Manuel J. Tan</i> | | | | 23B. DATE SIGNED <i>Sept. 11, 1966</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>MANUEL J. TAN</i> | | 23D. ADDRESS <i>CHURCH HOME & HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9-15-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>HOLY ROSARY CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <i>SEP 12 1966 R. G. E. Jackson</i> | | 25C. FUNERAL DIRECTOR <i>JOHN M. WEBER & SONS INC. 401 S. CHESTER ST</i> | | | |

8/10/66 C. of wife's car

Constance of the
Good Father
Pentecost, 2nd

in 1965

Vicent Jambouki

House wife

5th Floor

2/8/5

1940 Washington 89/125

1940 Washington 89/125

89/125

Washington 89/125

Washington 89/125

Washington 89/125

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

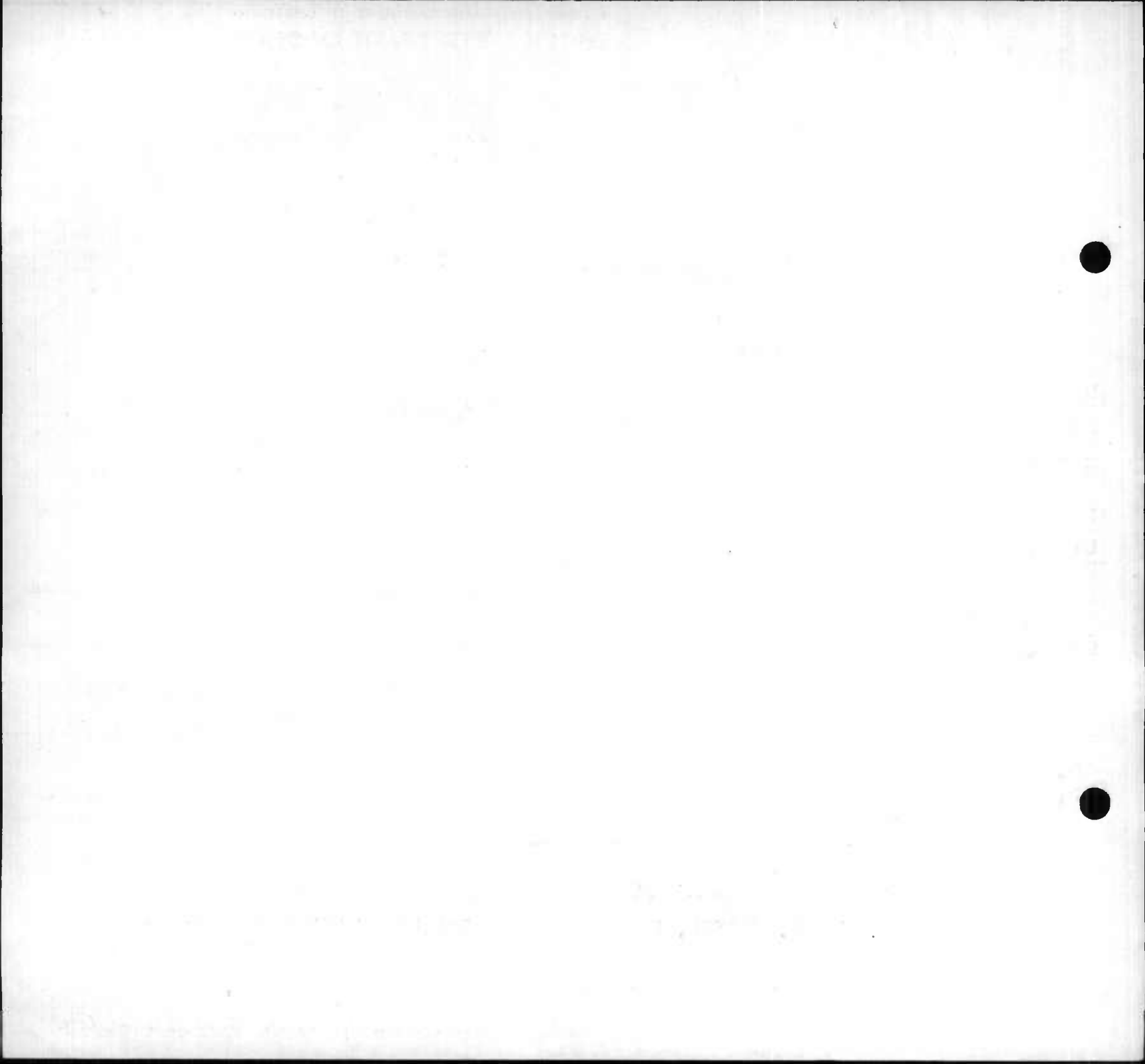
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|--|--------------|---|-----------------------------|--|---|
| BIRTH NO. 66 09201 | | CITY HEALTH DEPARTMENT | | Registered No. 66 09201 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MIKE JANKIEWICZ | | 2. DATE AND HOUR OF DEATH SEPT. 12, 1966 7:25 P.M. | |
| 3. PLACE OF DEATH BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSPITAL | | D. STREET ADDRESS (If rural, give location) 242 S EDEU ST | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 12-5-97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME FRANK JAN KIEWICZ | | 14. MOTHER'S MAIDEN NAME TINI ZYSKY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT PATIENT | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 154 XI | | CAUSE OF DEATH (A) DUE TO PERITONITIS, GENERALIZED LEAK FROM colostomy opening (B) DUE TO PNEUMONIA maligned drainage of unruptured bronchi septica (C) ADENOCARCINOMA Rectum | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs(?) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30-66 19 to 9-12-66 19, that (I) (we) last saw the deceased alive on 9-12 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel J. Tan | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 12, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-15-66 | | 24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM. | |
| 24D. LOCATION (City, town, or county) (State) BALTO | | 24E. FUNERAL DIRECTOR JOHN M. WEBER, 1508 N. CHESTER ST | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 12 1966 | | 25B. NAME OF REGISTRAR John E. Fairley | | 25C. ADDRESS MD | |

ADRIANO CARLINO
PUEBLO DE LOS ANGELES
PUEBLO DE LOS ANGELES
PUEBLO DE LOS ANGELES
PUEBLO DE LOS ANGELES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

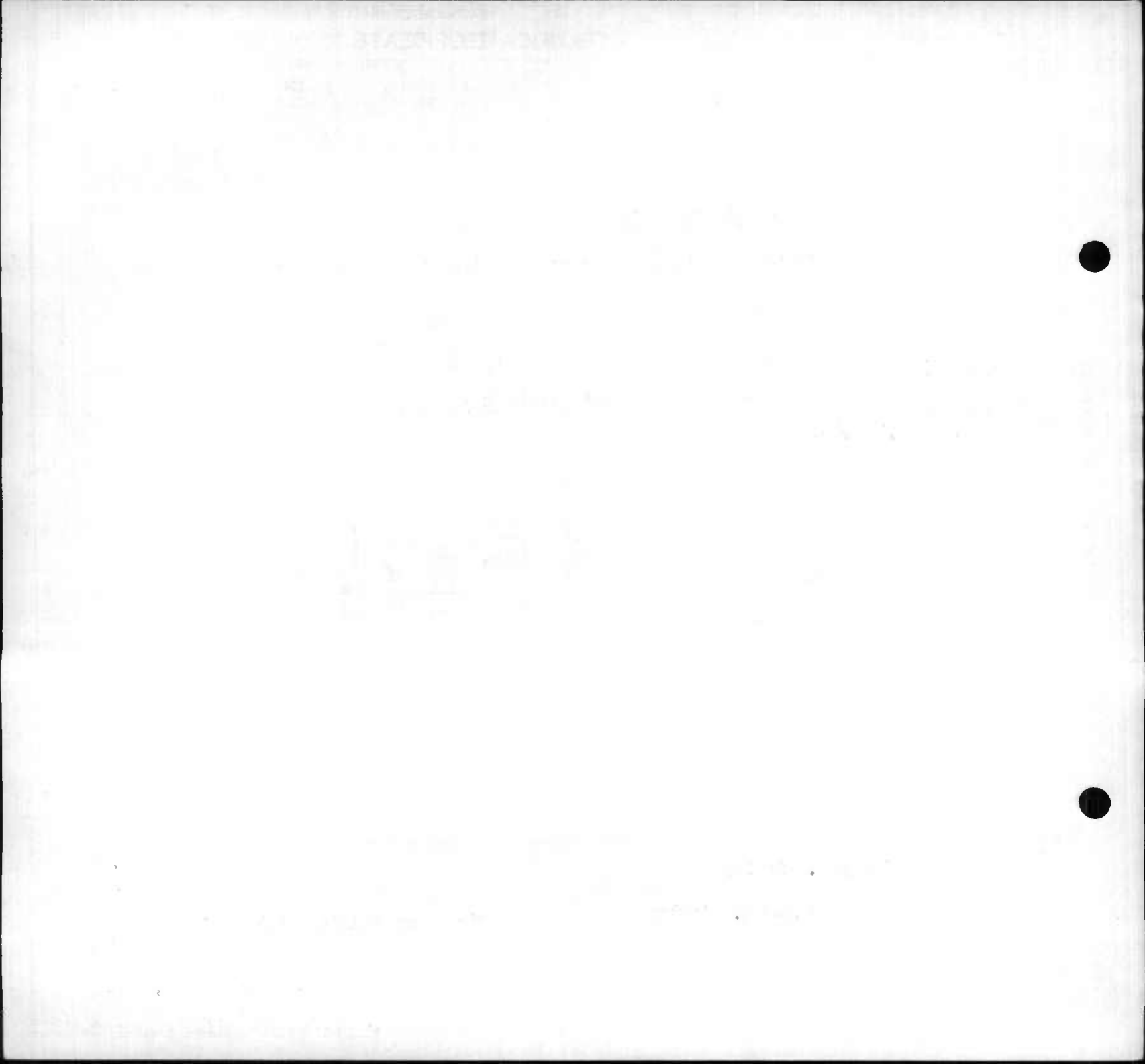
| | | | | | |
|--|---------------------|---|---|--|--|
| BIRTH NO. 66 09202 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09202 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Gloria K. Rumsley</i> | | | Sept 12, 1966 9:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i> | | | A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>851 Wellington Ave.</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3-30-35</i> | 9. AGE (In years last birthday) <i>31</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly line worker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Emblem Mfg.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Richard Koehler</i> | | 14. MOTHER'S MAIDEN NAME <i>Frieda Stercing</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no no</i> | | 16. SOCIAL SECURITY NO. <i>?</i> | | 17. INFORMANT <i>Mr Earl Rumsley</i> | |
| | | | | ADDRESS <i>same</i> | |
| 18. <i>330 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Subarachnoid hemorrhage</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>Sept. 11</i> 19 <i>66</i> to <i>Sept 12</i> 19 <i>66</i> , that the (we) lost saw the deceased alive on <i>Sept 12</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) the (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nat E. Watson, Jr.</i> | | | | 23B. DATE SIGNED <i>9/12/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. NAT E. WATSON, JR</i> | | | | 23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/15/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Parkwood</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Taylor Ave, Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Jackson</i> | | 25C. FUNERAL DIRECTOR <i>August E. Donovan - 3818 Roland Ave</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

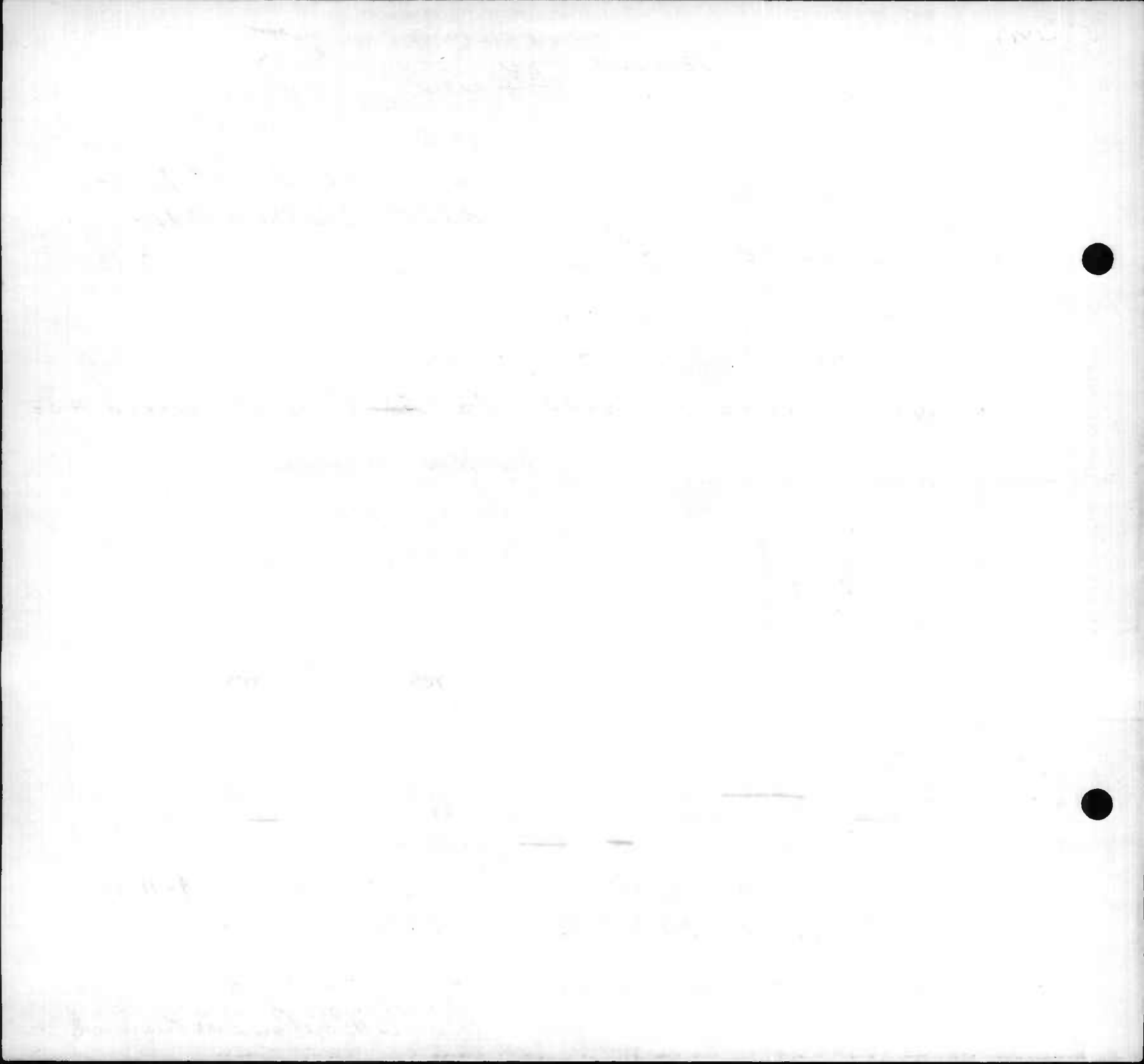
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09203</u> | |
|---|-------------------------|--|------------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. <u>66 09203</u> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>JEAN, WILLIAM J.</u> | | 2. DATE AND HOUR OF DEATH <u>1:45 AM Sept 11-1966</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL Hosp.</u> | | A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE Md.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3411 KESWICK ROAD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>5-13-93</u> | 9. AGE (In years lost birthday) <u>73</u> | 10. AGE (In years lost birthday) <u>73</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOSEPH JEAN</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY UNKNOWN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk</u> | | 16. SOCIAL SECURITY NO. <u>219-0376643</u> | | 17. INFORMANT ADDRESS <u>GRAYSON JEAN - STEVENSVILLE, MD.</u> | |
| 18. <u>151X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Carcinoma of stomach</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>unk-6mo.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0 mm</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-26-66</u> 19 <u>66</u> to <u>Sept 11</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>Sept 11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Sidney E. Kirkley</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>11 Sept 66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>SIDNEY E. KIRKLEY</u> | | M.D. 23D. ADDRESS <u>Union Memorial Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/14/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Old Frederick Rd, Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Audon E. Donovan - 3818 Roland Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

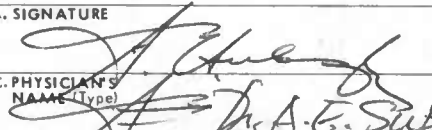
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66-19225 66 09204 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09204 | |
|---|-------------------------|--|-----------------------------------|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) TAVENNER EDWARD CHESTER TAVENNER | | 2. DATE AND HOUR OF DEATH 9-11-66 3:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - #7 53-00 | | D. STREET ADDRESS (If rural, give location) 3208 CRESSON AVE. | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 9-8-66 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months Days Hours Min. 13 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME EDWARD CHARLES TAVENNER | | 14. MOTHER'S MAIDEN NAME DOROTHY EVANS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS Ed. TAVENNER 3208 CRESSON AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 769.61 | | CAUSE OF DEATH (A) HYALINE MEMBRANE (B) PREMATURITY (C) MATERNAL DIABETES | | INTERVAL BETWEEN ONSET AND DEATH 2 Hrs 13 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 9-8-66 19 to 9-11-66 19, that (I) (we) last saw the deceased alive on 9-10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aleude A. Melocoton | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) ALEUDE A. MELOCOTON | | 23D. ADDRESS BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY London Park | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR R. E. Fink | | 25C. FUNERAL DIRECTOR Francis H. Miller | |
| ADDRESS 101 Frederick Ave | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09205 | |
| BIRTH NO. 66 09205 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH Sept. 8 - 1966 1:20 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Gertrude M. Napfel | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home + Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BELLEVILLE DUNDALK 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) 7201 Birch Ave. # 22 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-5-25 |
| | | 9. AGE (In years last birthday) 41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK-TYPIST | | 10B. KIND OF BUSINESS OR INDUSTRY MISTY HARBOR MFG. CO. | |
| 11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Conrad Turner | | 14. MOTHER'S MAIDEN NAME Jennie Mueller | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212-22-9274 | |
| 17. INFORMANT Francis A. Napfel - Same as above | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterial Hypertension + Polycystic Kidneys | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7 19 66 to Sept 8 19 66 , that (I) (we) last saw the deceased alive on Sept - 8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED 9-8-66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. A. E. Subong, Jr. | | 23D. ADDRESS Church Home + Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-12-66 | |
| 24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. | | 24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BALTO. CO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR Charles J. Seiler | | ADDRESS 901 S. CONKLING ST. BALTO., MD. | |

1947
Sept 2-1947
Sept 2-1947

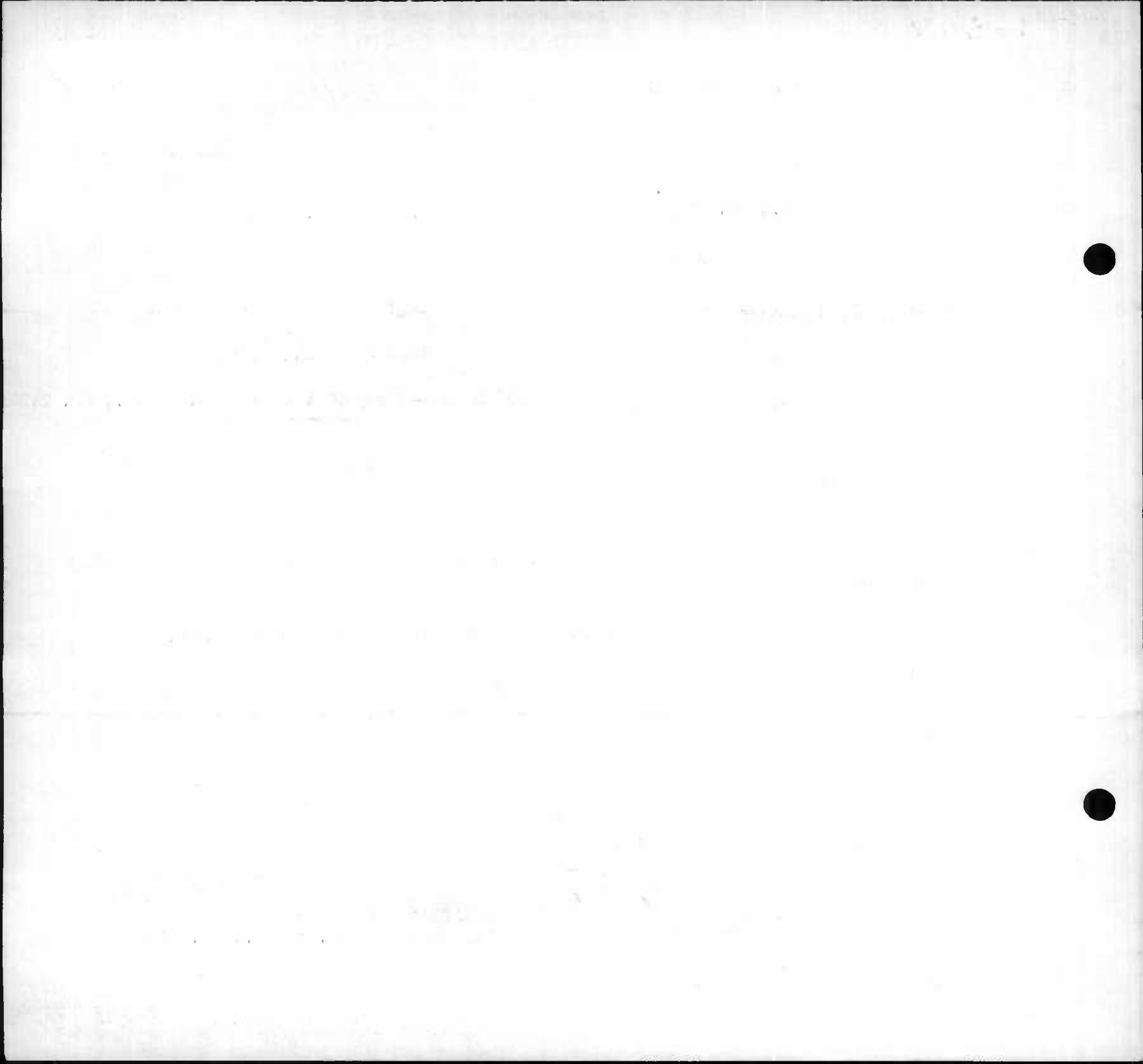
Church Home & Hospital 2501 Green Ave -
Female White Married 6-2-32, 41
Maryland
Gerald Turner
Gerald Miller

Female A. Noble - 2000
Subacute Hemorrhage
Arterial hypertension +
Polycystic kidneys

Sept 8
Sept 8

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

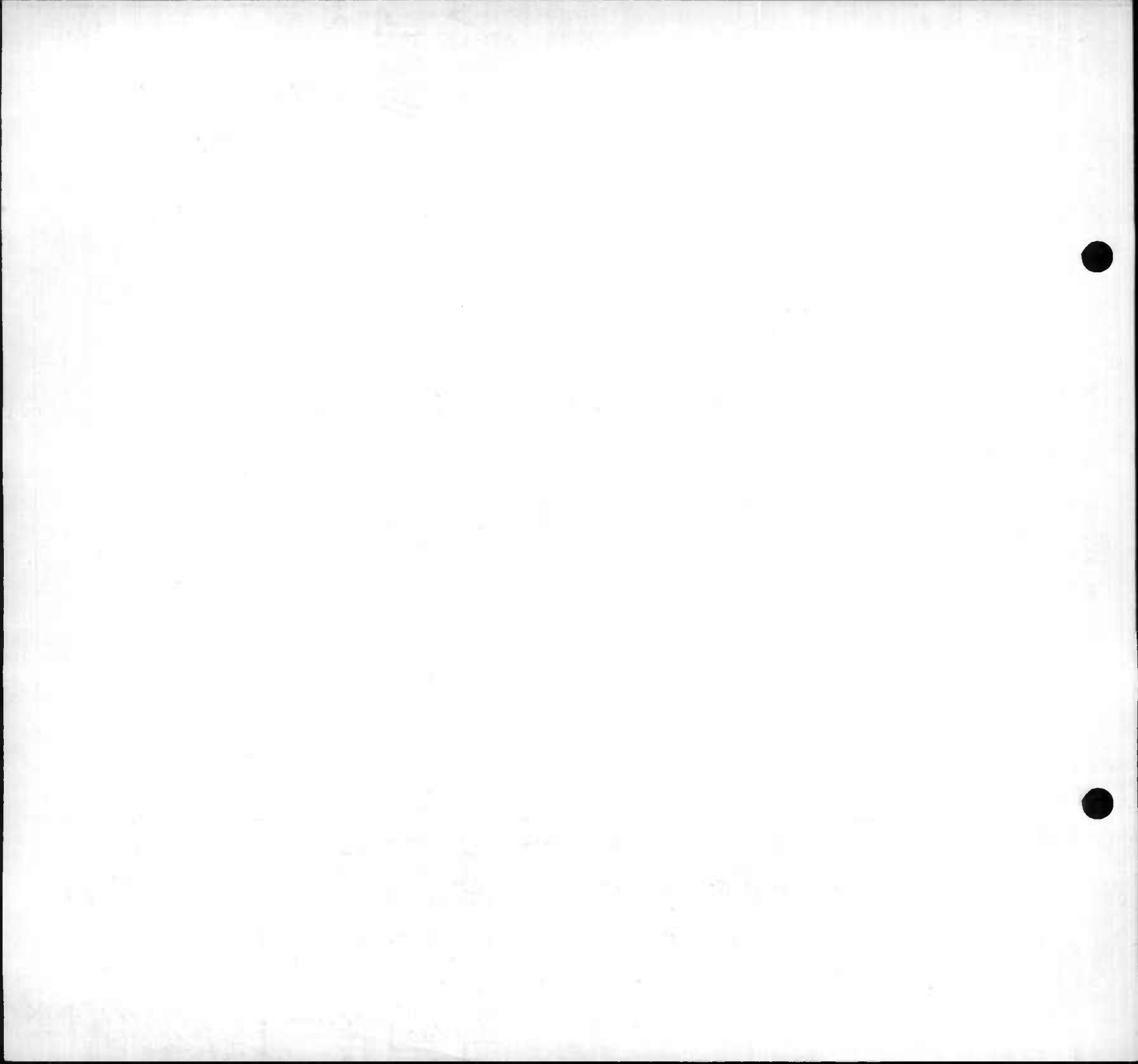
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09206 | |
|---|-------------------------|---|---|---|--|
| 66 09206 | | | | 66 09206 | |
| BIRTH NO. | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) ARTHUR HUMMELL | | | 2. DATE AND HOUR OF DEATH 9/11/66 7:40 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO., MD. 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 811 S. EAST AVE. 21224 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 2/22/06 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoeman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME JOSEPH | | | 14. MOTHER'S MAIDEN NAME ELIZABETH Nuber | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give way or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-09-1588 | | 17. INFORMANT ADDRESS RECORDS-BCM 4940 EASTERN AVE. BALTO., MD. 21224 | |
| 18. 322-11-0081 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) pneumonia (B) SEPSIS (C) chronic Alcoholism | | | INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 4 DAYS 10 YEARS | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. History of T.B. History of Peptic Ulcer | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/6 19 66 to 9/11 19 66 , that (I) (we) last saw the deceased alive on 9/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David Swimmer M.D. | | | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID Swimmer M.D. | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO., MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-15-1966 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR Helma A. Hoffmann | | 25D. ADDRESS 3218 Hudson St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09207 | |
|---|------------------|--|-------------------------------------|---|---|
| 66 09207 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Gilbert Johnson</u> | |
| 2. DATE AND HOUR OF DEATH <u>9/9/66 5:15 A.M.</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Big Falls Rd. Mount Airy</u> D. STREET ADDRESS (If rural, give location) <u>Big Falls Rd.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>11/30/11</u> | 9. AGE (In years last birthday) <u>54</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parts Manager</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Auto.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Frank Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Janie Owens</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> <u>W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>214-18-3710</u> | | 17. INFORMANT <u>Elaine Johnson</u> ADDRESS <u>Markton, Md</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>G.I. bleeding and shock</u> | | CAUSE OF DEATH (A) DUE TO (B) <u>Bowel Metastases of Retroperitoneal Carcinoma</u> (C) | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>8/30</u> 19 <u>66</u> to <u>9/9</u> 19 <u>66</u> , that (I) <u>(last)</u> saw the deceased alive on <u>9/9</u> 19 <u>66</u> and that in (my) <u>(last)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> <u>(last)</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>Murray A. Katz</u> M.D. | | | | 23B. DATE SIGNED <u>7/9/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Murray A. Katz</u> | | | | 23D. ADDRESS <u>The Johns Hopkins Hospital</u> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>9/13/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Beth. Nat. Cem.</u> | |
| 24D. LOCATION (City, town or county) (State) | | 24E. LOCATION (City, town or county) (State) <u>Balto. Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Chas. E. Blumenthal</u> ADDRESS <u>1701 Mt. Calvert Balto. Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 09208 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09208 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) MR. THOMAS PHILIP RIORDAN | | 2. DATE AND HOUR OF DEATH 9-8-66 10²⁵ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21213 D. STREET ADDRESS (If rural, give location) 3016 KENYON AVE. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, SEPARATED (Specify) MARRIED | 8. DATE OF BIRTH 8-11-84 | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GUARD | | 10B. KIND OF BUSINESS OR INDUSTRY GOVT. DEPOT | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME TIMOTHY RIORDAN IRELAND | | | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH (A) WHALEN IRELAND | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. II ARMY | | | |
| 16. SOCIAL SECURITY NO. 216-16-3403 | | 17. INFORMANT WIFE MRS. BRIDGET RIORDAN ADDRESS SAME | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 443X1 | | CAUSE OF DEATH (A) Hypertensive Arteriosclerotic VASCULAR DISEASE (B) Cerebral Thrombosis (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs. 4 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>SEPT. 4, 1966</u> to <u>SEPT. 8, 1966</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>SEPT. 8, 1966</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James W. Carty, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/8/66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES W. CARTY, JR. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-12-66 | | 24C. NAME OF CEMETERY or CREMATORY MOST HOLY REDEEMER | |
| 24D. LOCATION (City, town, or county) (State) BALTO., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR R. E. E. E. | | 25C. FUNERAL DIRECTOR J. Walter Conklin ADDRESS 5444 BELAIR Rd. | |

THE UNITED STATES OF AMERICA

1
M-260

66 09209

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09209

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN B. MAJOR

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1966 9:50 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

517 Cathedral Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

517 Cathedral Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

5/17/86

9. AGE (In years last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CHARLEMONT VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

ROBERT MAJOR

14. MOTHER'S MAIDEN NAME

GEORGIA BURKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MR. JOHN B. MAJOR, JR.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
9/8/66

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

9/13/66

23C. NAME of CEMETERY or CREMATORY

WOODLAWN CEMETERY

23D. LOCATION

(City, town, or county)

(State)

EMMIRA, N. Y.

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

H. W. MEARS & SON 805 N. CALVERT ST

ADDRESS

WALLLEY FORRE

ALL INFORMATION

DR. JOHN E. WALLLEY, JR.

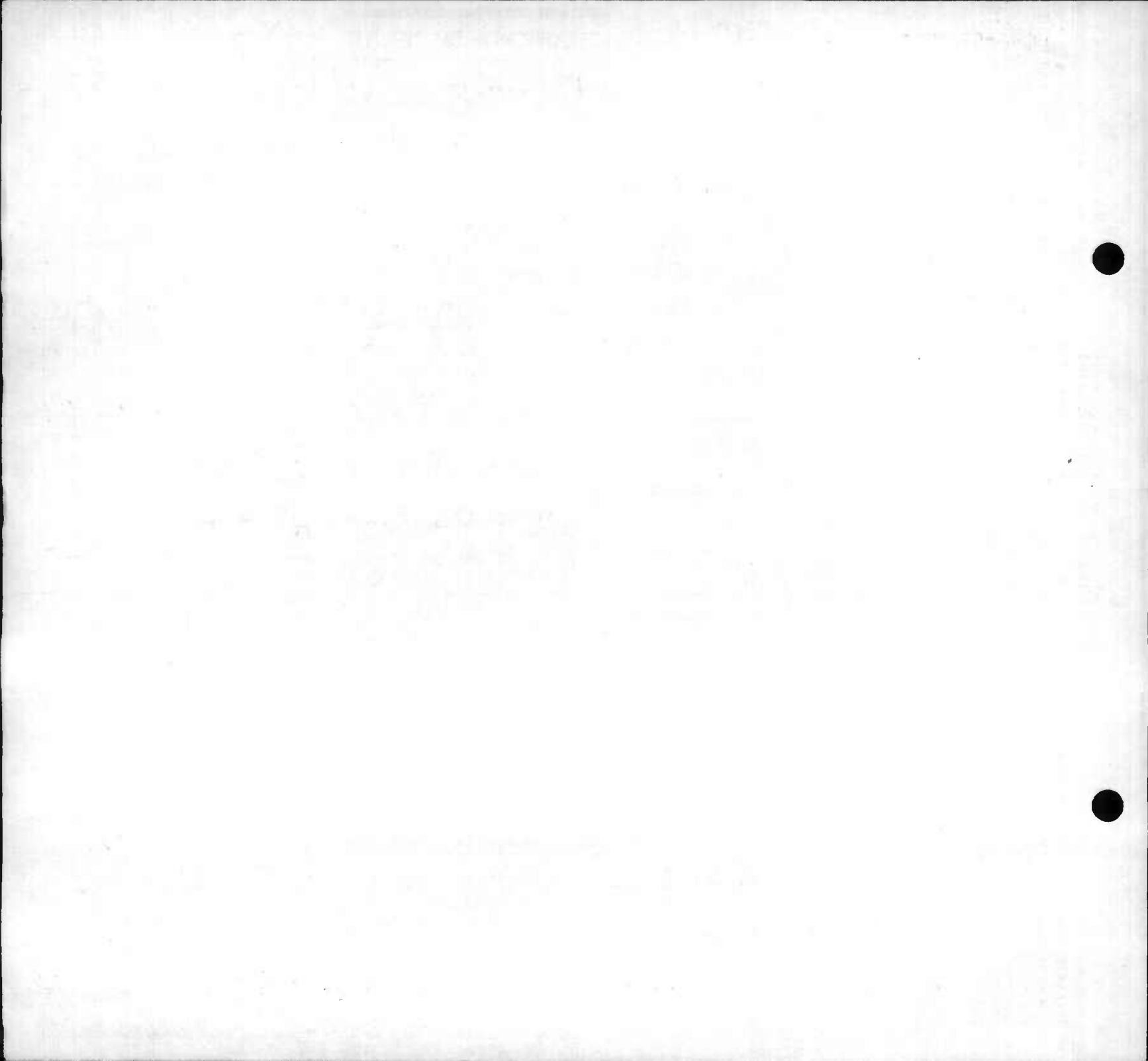
ALL INFORMATION

ALL INFORMATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

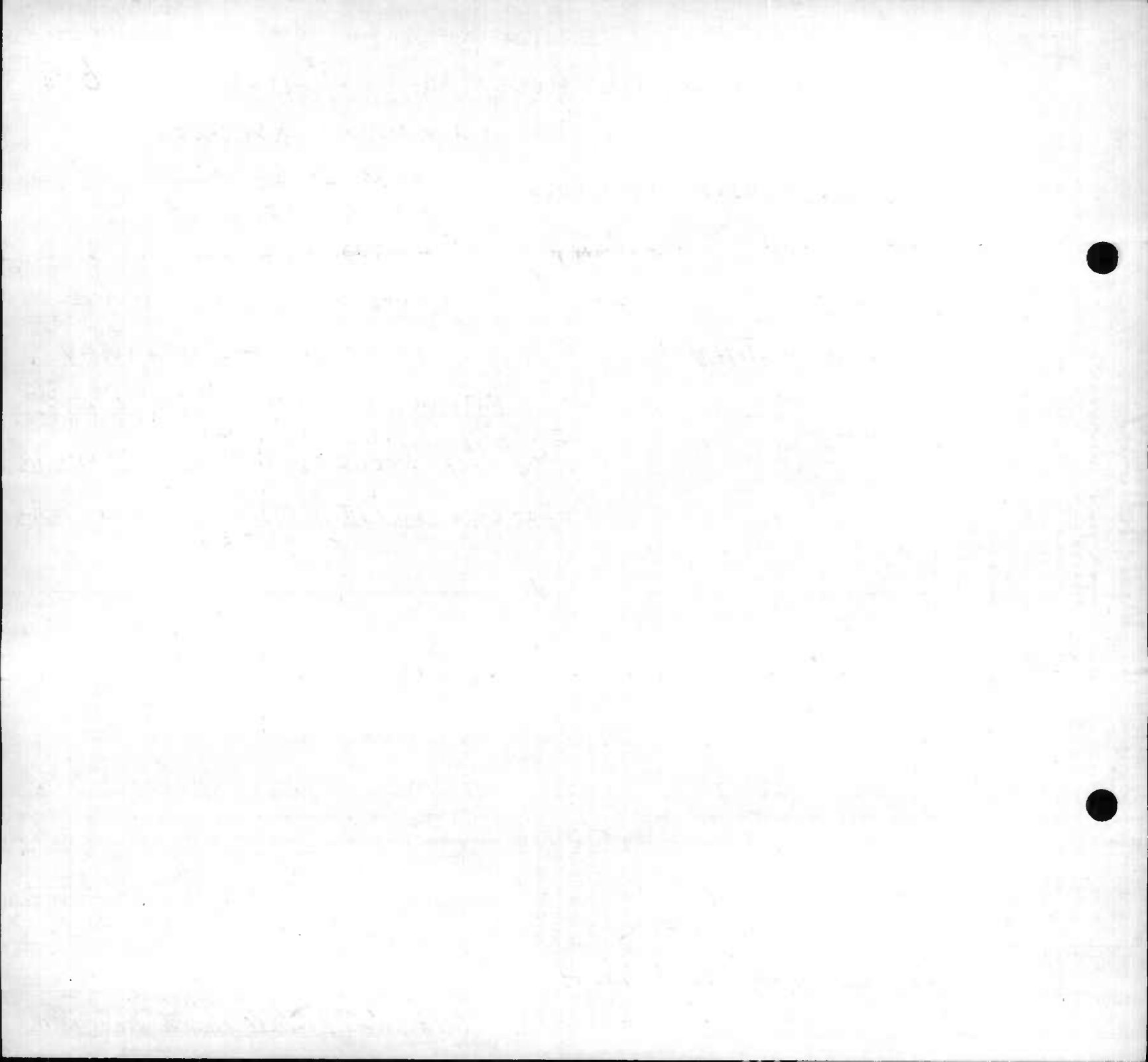
| | | | | | |
|--|---------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09210 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>66 09210</u> | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Benedict, Jessie</u> | | 2. DATE AND HOUR OF DEATH <u>9.10.66</u> <u>10¹⁵ PM</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u> <u>38</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CARROLL CO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>NEW WINDSOR</u> <u>56-00</u> D. STREET ADDRESS (If rural, give location) <u>127 MAIN ST.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | 8. DATE OF BIRTH <u>6/9/85</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Wm. D. Lovell SR</u> | | 14. MOTHER'S MAIDEN NAME <u>IDA S. LONAKER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>800-00-4245</u> | | 17. INFORMANT <u>WILLIE BENEDICT NEW WINDSOR MD</u> | |
| 18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HT FAILURE</u> HEART <u>ARTERIOSCLEROTIC DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Ventral Hernia</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input type="checkbox"/> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9.10.66</u> 19 <u>66</u> to <u>9.10.66</u> 19 <u>66</u> and that (I) (we) last saw the deceased alive on <u>9.10.66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Stuart L. Fine</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9.10.66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>STUART L. FINE</u> | | 23D. ADDRESS M.D. <u>UNIV. HOSP. BALTO 1, MD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/13/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>WINTERS</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>NEW WINDSOR RURAL MD</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1966</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Johnson</u> | |
| 24G. FUNERAL DIRECTOR <u>NEW WINDSOR</u> | | 24H. ADDRESS <u>NEW WINDSOR</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09211 | |
|---|---------------------|--|--|--|---|
| BIRTH NO. 66 09211 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CRESWELL, MRS. HELEY MAE | | 2. DATE AND HOUR OF DEATH 9-11-1966 6:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSPITAL | | A. STATE MARYLAND B. COUNTY HARFORD | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAVRE DE GRACE 62-24 | | | |
| | | D. STREET ADDRESS (If rural, give location) 570 N. ADAMS ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-28-1899 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) HAVRE DE GRACE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME WERNER - JOHN | | | 14. MOTHER'S MAIDEN NAME MITCHELL - EDITH MAY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS SGT MRS R.G. MITCHELL, H.B.CO. OCS BDE. APO - M.P. | | |
| 18. 7-22-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INFECTED (PROB. SEPTICEMIA) (A) MULTIPLE DECUBITUS ULCERS DUE TO: 8 MONTHS | | (B) FAR ADVANCED RHEUMATOID ARTHRITIS DUE TO: MANY YEARS | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-19-1966 to 9-11-1966 that (I) (we) last saw the deceased alive on 9-11-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Zin U. Park | | | | 23B. DATE SIGNED 9-11-1966 | |
| 23C. PHYSICIAN'S NAME (Type) ZIN U. PARK | | | | 23D. ADDRESS MONTEBELLO STATE HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-14-1966 | | 24C. NAME OF CEMETERY or CREMATORY ANGEL HILL CEM. | |
| 24D. LOCATION (City, town, or county) (State) HAVRE DE GRACE, MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR R. Madison Mitchell | | 25C. FUNERAL DIRECTOR ADDRESS Havre Grace, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

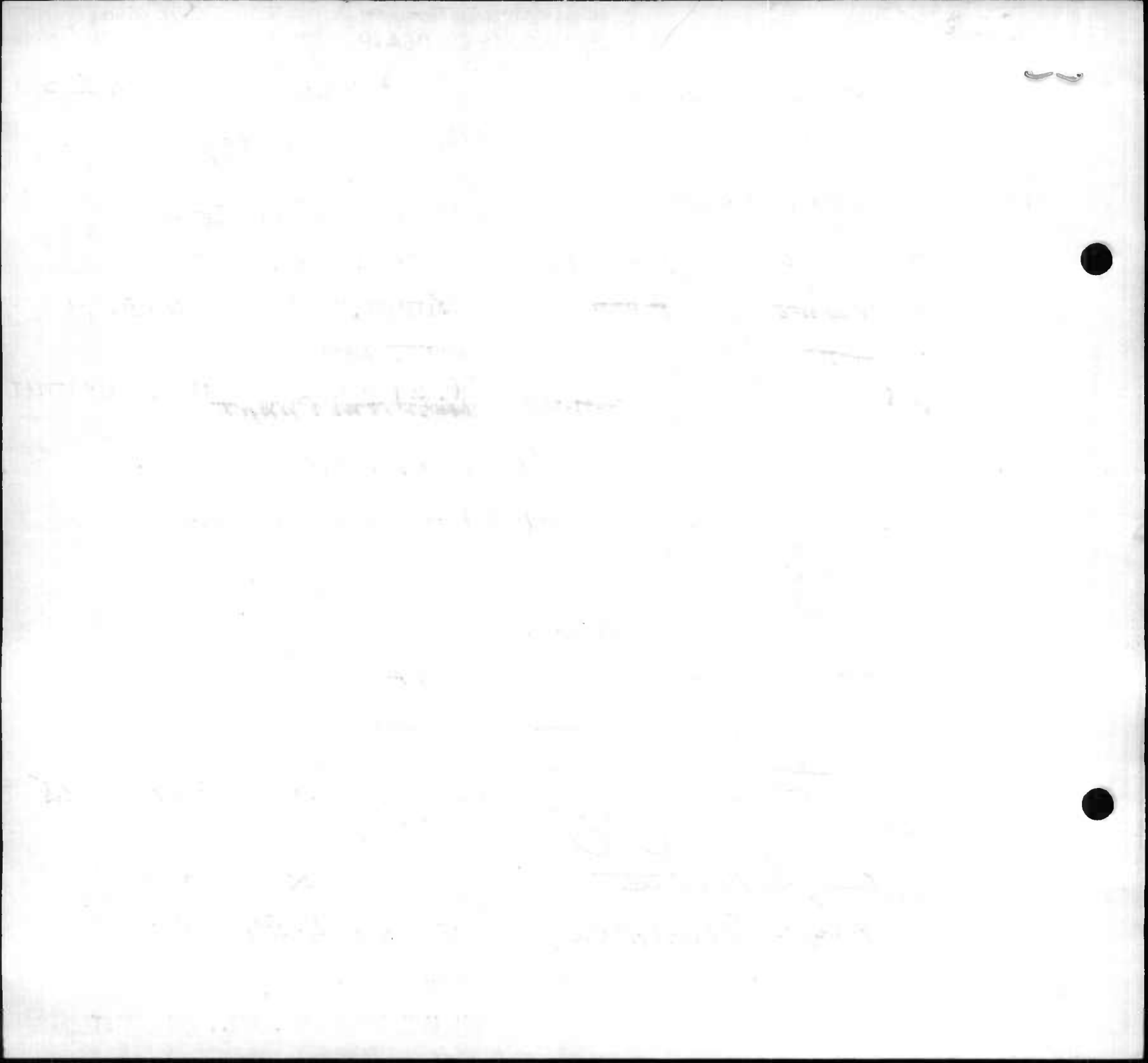
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|---|---|---|---|--|--|
| BIRTH NO. 66 09212 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09212 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) JACOB I. COOPER | | | 2. DATE AND HOUR OF DEATH 9/10/66 2:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-41 D. STREET ADDRESS (If rural, give location) 4405 KENNISON AVE. #15 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 9/25/90 | 9. AGE (In years lost birthday) 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer | | 10B. KIND OF BUSINESS OR INDUSTRY Mens Pants | | 11. BIRTHPLACE (State or foreign country) Latvia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Henry Cooper | | |
| 14. MOTHER'S MAIDEN NAME Sarah ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Ida Cooper-- Same | | | |
| 18. 260X I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ascend Aortic Aneurysm | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 19 9/10 19 66 , that (I) was lost saw the deceased alive on 9/10/66 19 9/10 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Milton B. Kirsch M.D. | | | | 23B. DATE SIGNED 9-10-66 | |
| 23C. PHYSICIAN'S NAME (Type) Milton B. Kirsch | | | | 23D. ADDRESS 4000 W. Northern Parkway | |
| 24A. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 24B. DATE 9/11/66 | | 24C. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cong. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd. | | | |

2



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

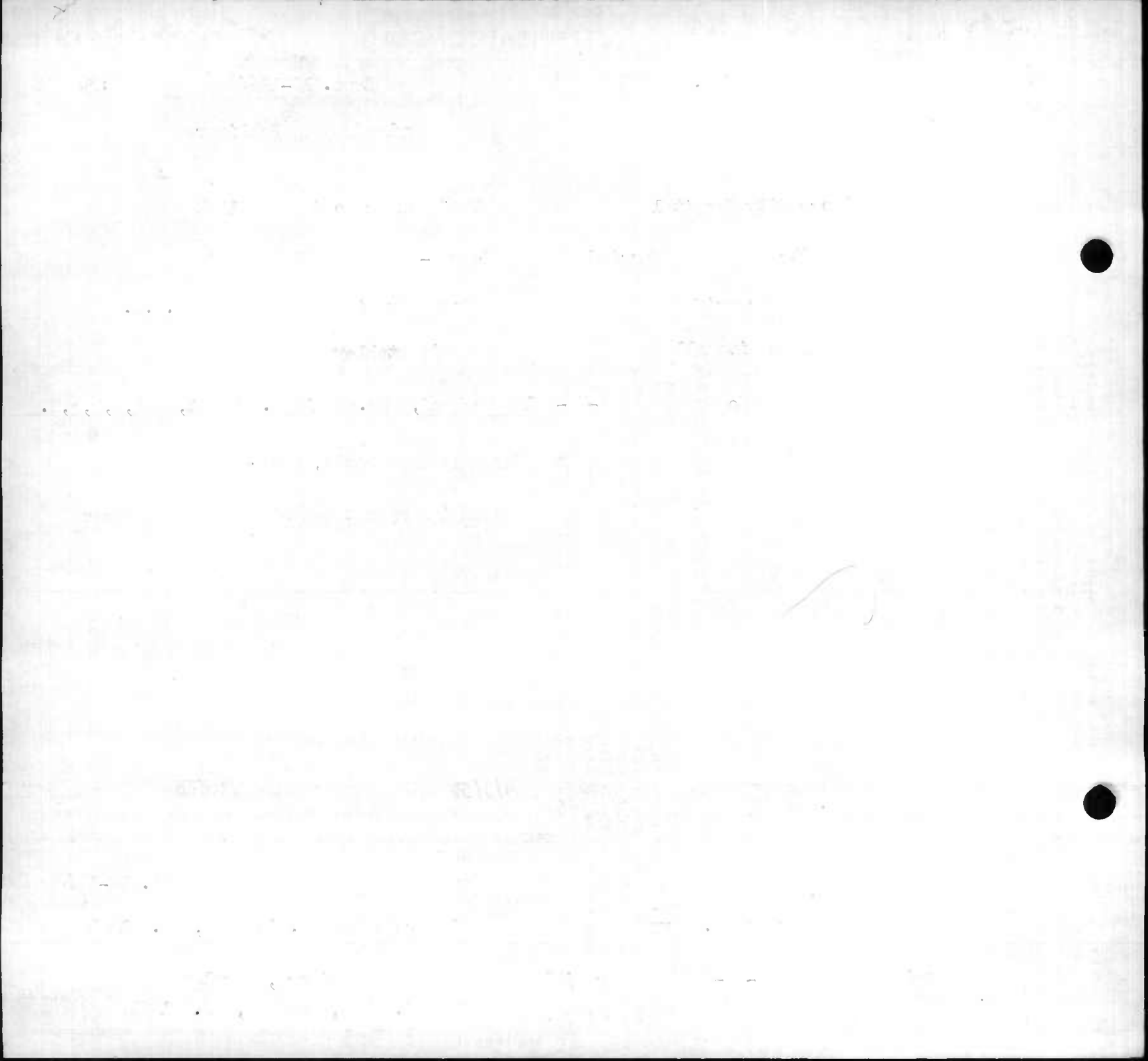
| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 66 09213 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09213 | |
| 1. NAME OF DECEASED (Type or Print) MITZI HEYMAN | | | 2. DATE AND HOUR OF DEATH 9-11-66 10¹¹ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-09 | | |
| | | | D. STREET ADDRESS (If rural, give location) 2911 MT. HOLLY ST. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-19-15 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. A |
| 13. FATHER'S NAME WOLF BENZION | | | 14. MOTHER'S MAIDEN NAME ANNA E. SAMUELS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-01-3963 | 17. INFORMANT ADDRESS MR. SIDNEY J. HEYMAN 2911 MT. HOLLY STREET | | |
| 18. 202,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEMATEMESIS. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GIANT FOLLICLE LYMPHOMA | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from 8-12 19 65 to 9-11 19 65 , that (I) <u>(we)</u> last saw the deceased alive on 9-11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alvin Schachter M.D. | | | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER M.D. | | | | 23D. ADDRESS SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY HAR ZION TIFERETH ISRAEL | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Paul E. Farkas | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | |
|--|----------------------------------|--|---|---|--|--|
| BIRTH NO. 66 09214 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09214 | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) RUTH L. ABBOTT | | | 2. DATE AND HOUR OF DEATH Sept. 10-1966 7:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 7055 Dunbar Road 21222 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH July 6-1909 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Mitchell | | | 14. MOTHER'S MAIDEN NAME Annie Stahley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-28-9912 | 17. INFORMANT ADDRESS Husband, Mr. Edwin B. Abbott, # 4, a, b, c, d. | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Coronary thrombosis, acute DUE TO (B) Essential hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 7 years | |
| | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 4/3/59 19 to 9/10/66 19, that (I) (we) last saw the deceased alive on 9/10/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | | |
| 23A. SIGNATURE Eugene F. Nevy | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 12-1966 | |
| 23C. PHYSICIAN'S NAME (Type) Eugene F. Nevy | | | 23D. ADDRESS M.D. 7001 Mornington Rd. Dundalk, Md. 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept-14-1966 | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Dundalk, Md. 21222 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 32-93-09 | |
|---|-----------------------------|---|------------------------------------|---|--|
| BIRTH NO. 66 09215 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Kelly, Darlene V. Kelly | | 2. DATE AND HOUR OF DEATH 8:00 PM 9/11/66 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | A. STATE Baltimore B. COUNTY Rosewood State Hospital C. CITY OR TOWN (If outside city limits, write RURAL and give township) Owings Mills, Md. D. STREET ADDRESS (If rural, give location) 53-00 | | | |
| 5. SEX Female | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 3-17-48 | 9. AGE (In years last birthday) 18 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Charles Kelly | | 14. MOTHER'S MAIDEN NAME Bortner Mary | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT admission record | |
| 18. 570.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Pneumonia | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 9/2 → 9/12 | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. cecal volvulus | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 9/2/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cecal volvulus | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) none | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Home <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none | |
| 22. I certify that (I) (his hospital) attended the deceased from 8/30 1966 to 9/12 1966 that (I) (we) last saw the deceased alive on 9/12 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 21F. HOW DID INJURY OCCUR? none | | | |
| 23A. SIGNATURE Fred R. Eilber | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) FRED R. EILBER | | M.D. | | 23D. ADDRESS University Hospital Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/14/66 | 24C. NAME OF CEMETERY or CREMATORY St. Johns Cemetery | | 24D. LOCATION (City, town, or county) (State) Littlestown, Adams Co., Penna. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Fadden | | 25C. FUNERAL DIRECTOR Richard A. Little | |
| | | | | ADDRESS Littlestown, Pa. | |

For the purpose of this study

Mr. J. P. Bennett

- 04 *Shirley Lee*

2015/5/27

2504

9.1P

rad3 & best

7550 R. F. 1120

Received A. 10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|--|------------------|--|---|--|---|-------------------------------------|-----------------------------------|--|---|--|------------------------------|--|--|
| BIRTH NO. 66 09216 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 66 09216 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Anna B. Reisig</i> | | | | | | | | | | 2. DATE AND HOUR OF DEATH <i>Sept 8 66 5 0 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Gould Nur Home</i> | | | | | A. STATE <i>Md</i> | | | | | C. CITY OR TOWN <i>Balto</i> | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | | (If outside city limits, write RURAL and give township) <i>26-09</i> | | | | |
| D. STREET ADDRESS (If rural, give location) <i>3799 Hudson St</i> | | | | | 8. DATE OF BIRTH <i>March 15 19 87</i> | | | | | 9. AGE (In years last birthday) <i>87</i> | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>John Betz</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Marg. Fochkoll</i> | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Cath C. Reisig</i> | | | ADDRESS <i>Same</i> | | | | |
| 18. <i>450.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) DUE TO <i>Arteriosclerosis</i> | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) DUE TO <i>Generalized Arteriosclerosis</i> | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (C) <i>Syn.</i> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (the hospital) attended the deceased from <i>JUNE 1 1966</i> to <i>AUG 8 1966</i> , that (1) (we) last saw the deceased alive on <i>AUG 6 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>Emmett P. Davis</i> | | | | | | | | | | 23B. DATE SIGNED <i>9/9/66</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Emmett P. Davis, M. D.</i> | | | | | | | | | | 23D. ADDRESS <i>5317 Belair Road Balto. 21206</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>Sept. 11 66</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY <i>St. Louis Heart</i> | | | | |
| 24D. LOCATION (City, town, or county) <i>Balto Co</i> | | | | | 24E. LOCATION (State) <i>Md</i> | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1966</i> | | | | | 25B. NAME OF REGISTRAR <i>John E. Feltner</i> | | | | | 25C. FUNERAL DIRECTOR <i>Pa. Steeman (606) 744 Rd</i> | | | | |

66 09217

BALTIMORE CITY HEALTH DEPARTMENT

66 09217

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

John Henry Milburn

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1966 5:33 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2021 Hoffman Street, East

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2021 E. Hoffman Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

August 12, 1915

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Park Hall, Maryland

12. CITIZEN OF
WHAT COUNTRY?

United States of America

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-05-9501

17. INFORMANT

WIFE

ADDRESS

ELIZA MILBURN 2021 E. Hoffman St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Arteriolar sclerosis of interventricular
septum with extensive interstitial
myocardial fibrosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Charles S. Springate, M.D.
NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9-15-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 13 1966

Robert E. Fairbank

Sealman McCarroll

WALLLEY BOUTGIE

RECEIVED

1914

1914

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1914

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1914

1914

1914

1914

1914

5-130

66 09218

BALTIMORE CITY HEALTH DEPARTMENT

66 09218

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Danny M. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1966 9:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1431 E. Clement Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

2/9/47

9. AGE (In years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Apprentice Printer - Diamond Press

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Q.T. Smith

14. MOTHER'S MAIDEN NAME

Alfreda Klemmick

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes 2/28/44 thru 9/10/46

16. SOCIAL
SECURITY NO.

215-46-6914

17. INFORMANT

Q.T. Smith 1431 E. Clement St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia complicating fracture C2-C3
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?17th St. & Philadelphia Ave.,
(St. Rte. #528) Ocean City, Maryland21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-5-66
9-9-66- ? m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hit as pedestrian by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/14/66

23C. NAME of CEMETERY or CREMATORY

Baltimore & National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1966

24B. NAME OF REGISTRAR

R. E. Edwards

24C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue

ADDRESS

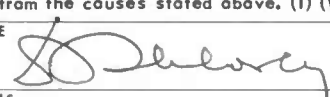
Letter from M.E.'s office 10-5-66 M.H.

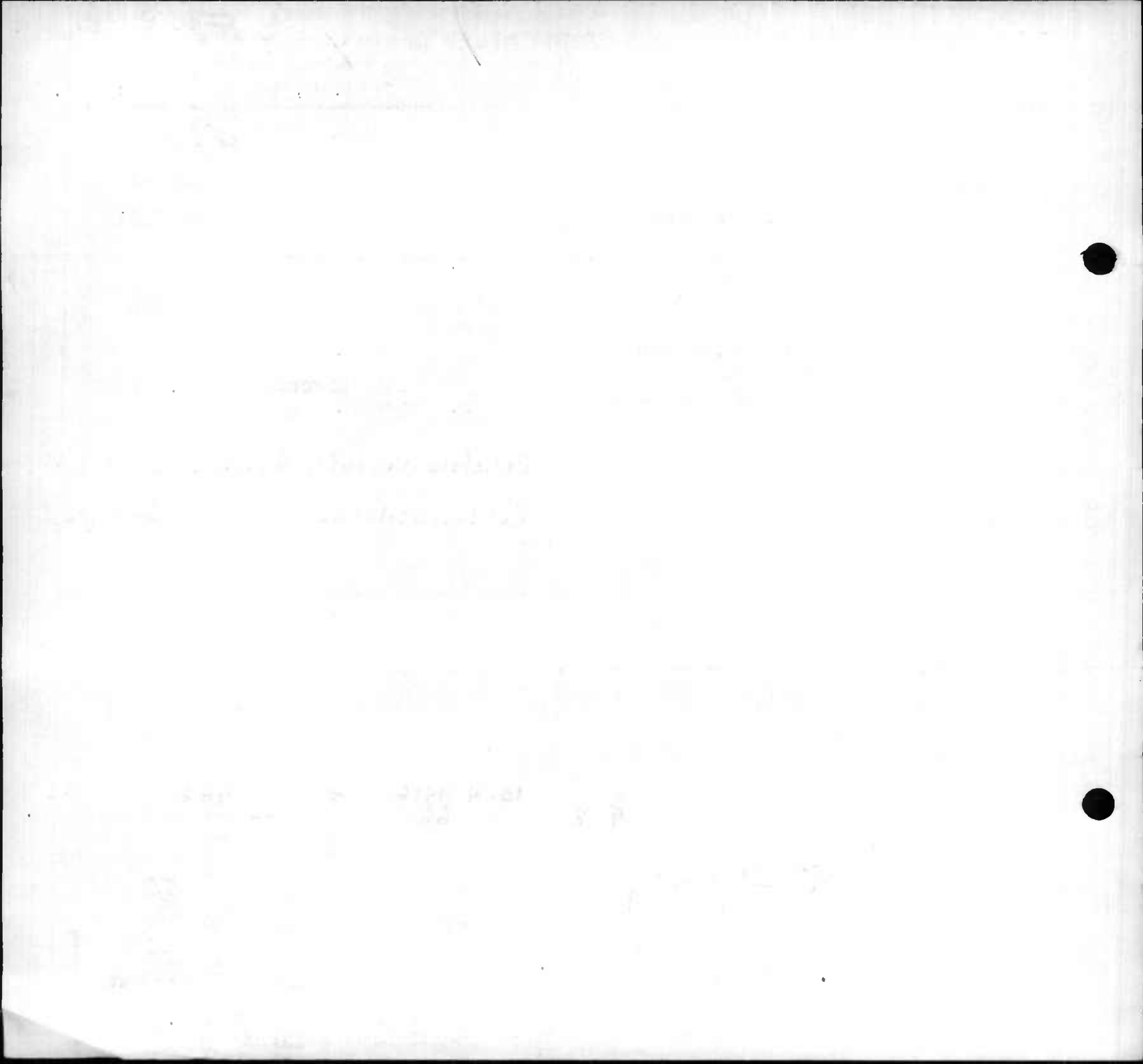
VALLEY JUDGE

Y

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--|---|--|
| BIRTH NO. 66 09219 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09219 | |
| 1. NAME OF DECEASED (Type or Print) HANNAH PULKKA | | 2. DATE AND HOUR OF DEATH SEPT. 10, 1966 7:50 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium 6116 Belair Road | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1102 Litchfield Road 21212 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Dec. 23, 1882 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Finland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Berhard Kervinen | | 14. MOTHER'S MAIDEN NAME Anna O. Kinnunen | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213 07 5691 | | 17. INFORMANT ADDRESS 1102 Litchfield Rd. 21212 Mr. Jorma H. Pulkka | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebrovascular Accident (B) Arteriosclerosis (C) INTERVAL BETWEEN ONSET AND DEATH 5 months 20 yrs | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-9-1966 to 9-8-1966 , that (I) (we) last saw the deceased alive on 9-8-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph Skloven | | 23D. ADDRESS M.D. 7122 Harford Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/13/66 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore Maryland | | | |



66 09220

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

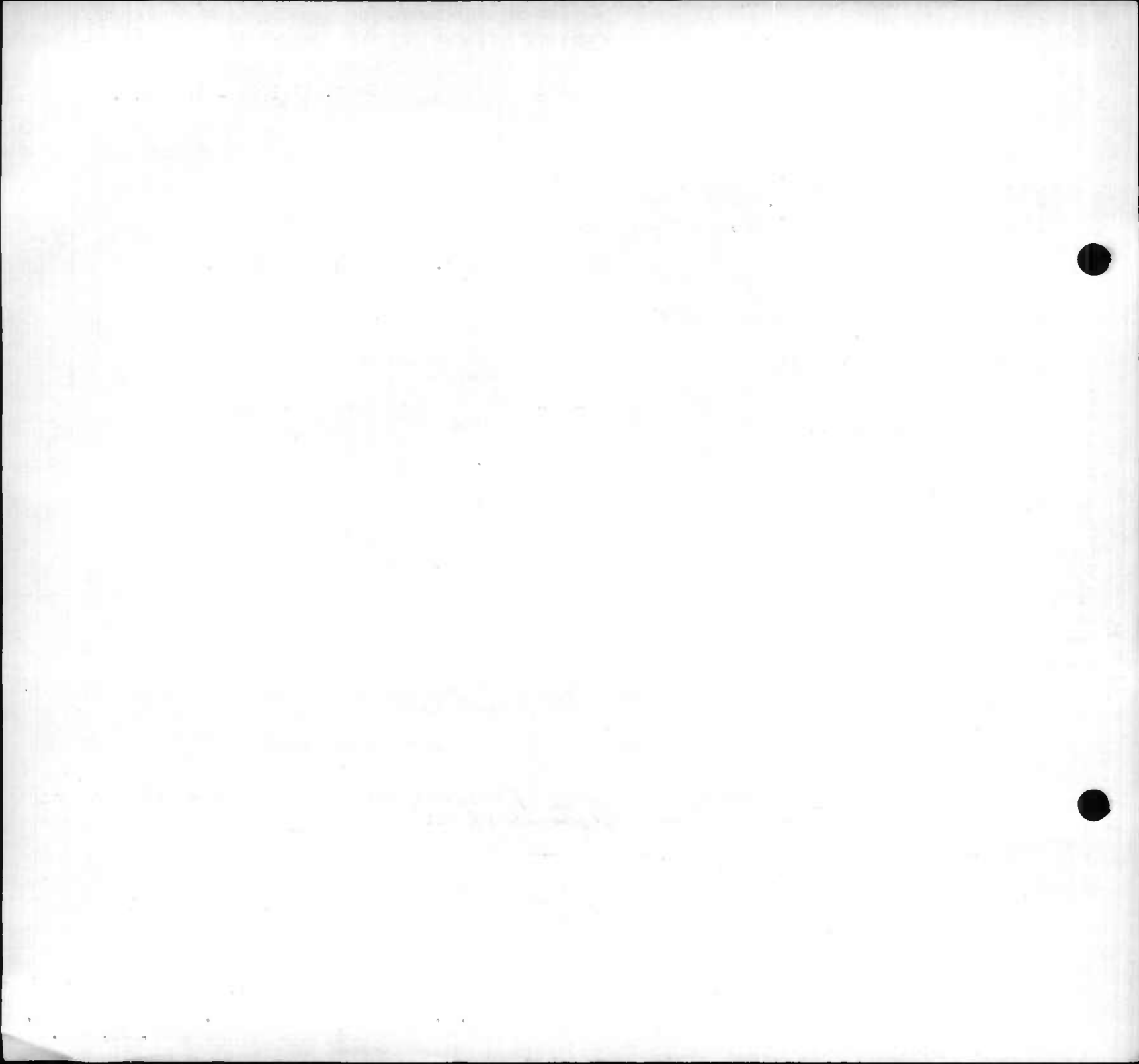
| | | | |
|---|---|---|--|
| NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| John Henry Jones | | 9-10-66 12:50 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY | |
| Johns Hopkins Hospital DOA | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | Baltimore 18-03 | |
| | | 109 Hayes St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| M | N | Married | 2/23/30 |
| 9. AGE (In years last birthday) | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) |
| 36 | Chauffeur | | Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| U.S.A. | | LeRoy Jones | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Elizabeth Robinson | | No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | Hilda Jones 748 Ryan St. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| E-8164 I | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | Fracture-dislocation C1-C2 | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| ANTECEDENT CAUSES | | (B) DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) DUE TO | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 2 | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | Highway | Rte 40 1/2 mile east of Allender Rd. | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 9-10-66 12:15 a.m. | | In stalled car struck by another car | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | |
| Charles S. Springate | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Charles S. Springate, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 9-10-66 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | 9/14/66 | Mt. Auburn | Baltimore, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | ADDRESS |
| SEP 13 1966 | Robert E. Fisher, M.D. | Charles A. Rice | 661 W. Barre St. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

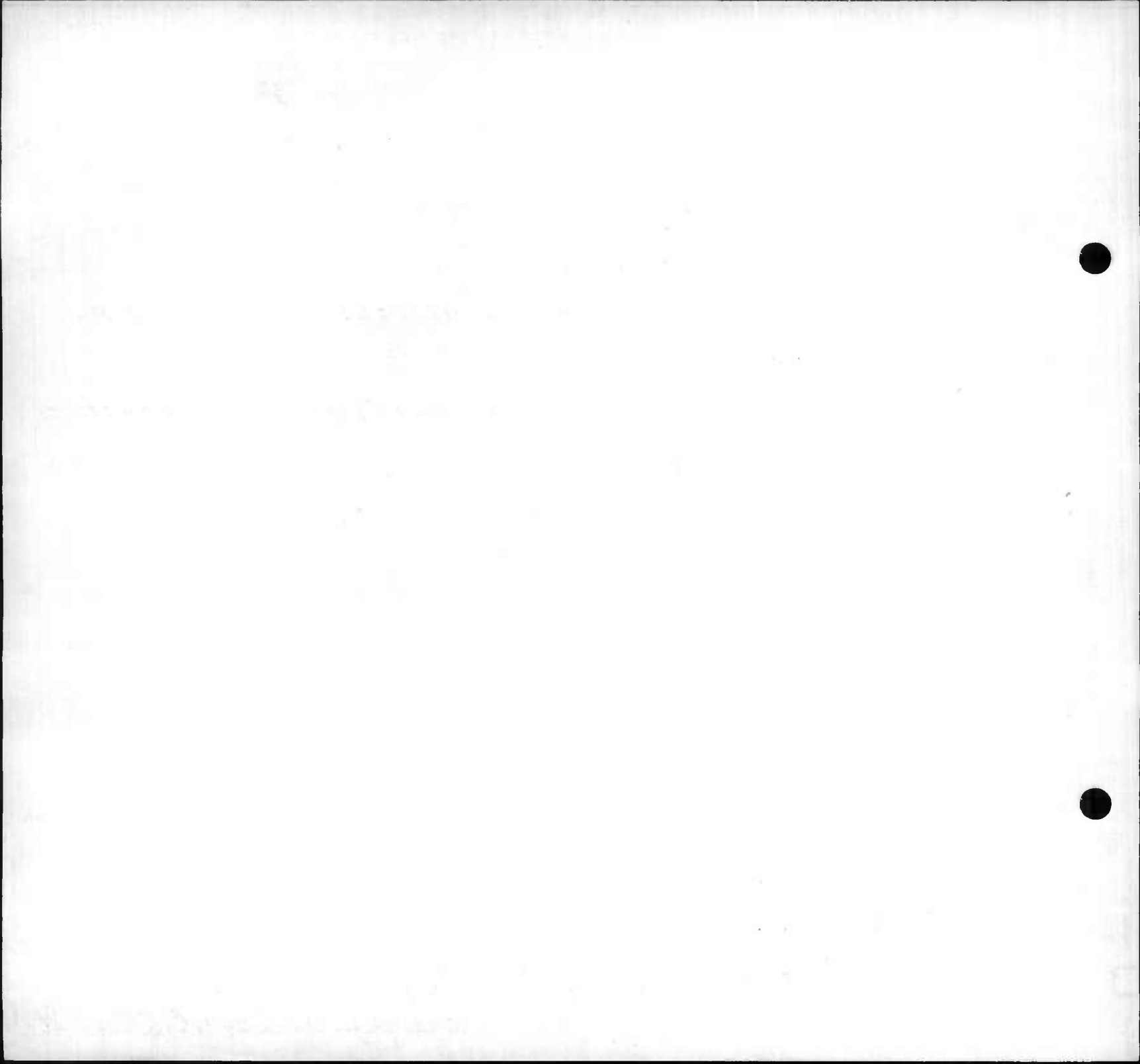
| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 66 09221 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09221 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE AGNES MONTGOMERY | | 2. DATE AND HOUR OF DEATH Sept. 11, 1966 - 1:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Jenkins Memorial Hospital 1000 S. Caton Avenue Baltimore, Maryland 21229 | | A. STATE Maryland B. COUNTY 27-48 | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH Jan. 1, 1874 - 92 yrs. | | 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Industrial | | 11. BIRTHPLACE (State or foreign country) Texas, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Michael Kelly | | 14. MOTHER'S MAIDEN NAME Catherine Kelly | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-09-6351 | | 17. INFORMANT Medical Records Room | |
| 18. 420.0 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Uremia | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ASHD | | | |
| | | (C) Sen. arteriosclerosis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 15, 1963 to September 11, 1966 , that (I) (we) lost saw the deceased alive on September 11, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel J. Rodriguez | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL J. RODRIGUEZ | | M.D. | | 23D. ADDRESS 435 CHALFONTE DR BALTO 22 MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/1966 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

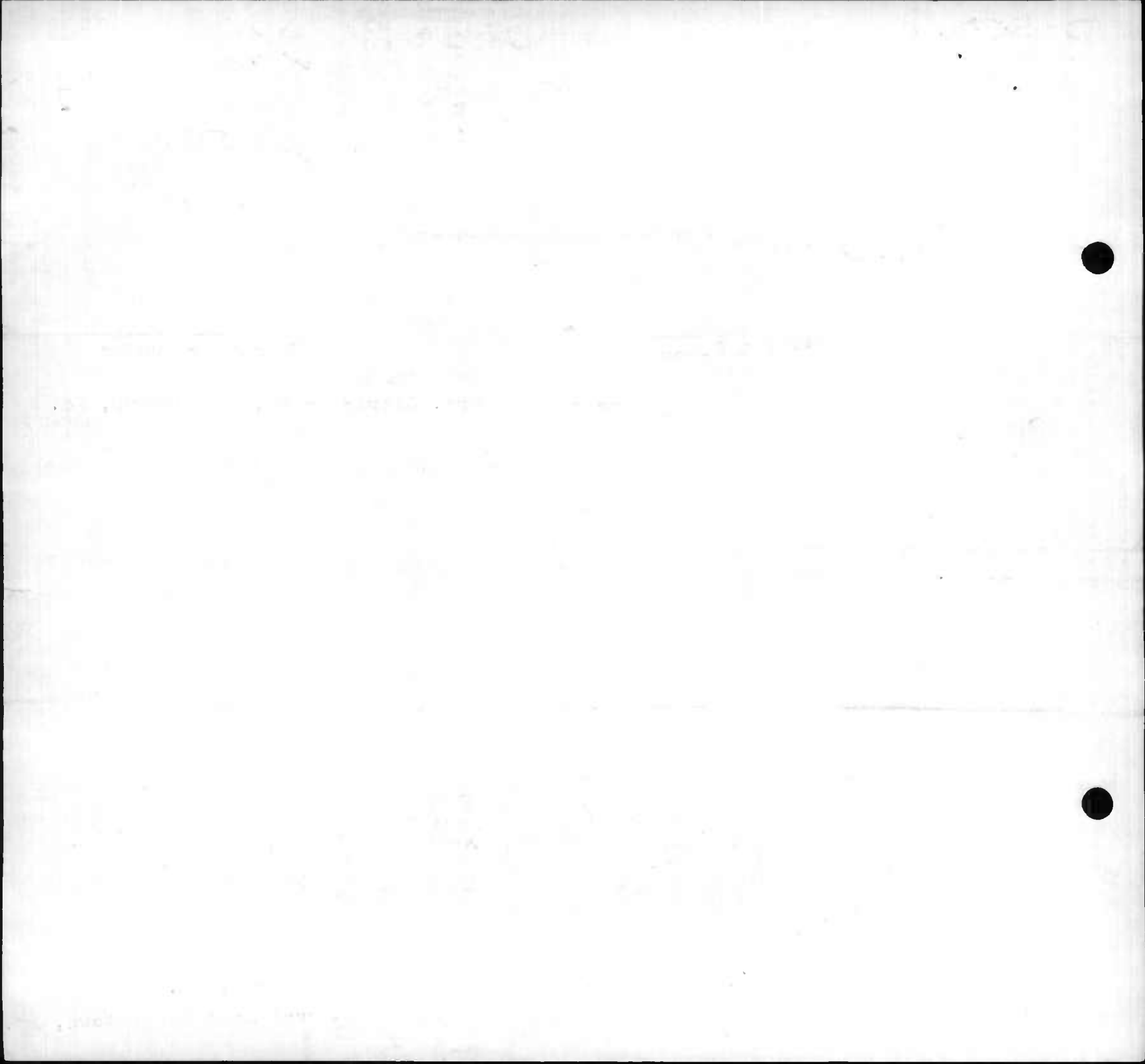
| | | | | | |
|---|---------------------|--|-----------------------------------|---|---|
| BIRTH NO. 66 09222 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09222 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) TRAFTON HARRY | | 2. DATE AND HOUR OF DEATH 9/11/66 12¹⁵ AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Md. B. COUNTY 8-06 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1512 Rutland Ave | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/7/15 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Plastic | | 11. BIRTHPLACE (State or foreign country) Bellscross, N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME I.M. TRAFTON | | | |
| 14. MOTHER'S MAIDEN NAME IDA BARTLETT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 238-12-4602 | | 17. INFORMANT Mrs Annis Trafton | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage | | 19. CAUSE OF DEATH (A) DUE TO Hypertensive Cardiovascular Disease (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 12-18 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10/66 19 to 9/11/66 19, that (I) (we) last saw the deceased alive on 9/11/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.H. Brown, III | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) C.H. BROWN 3RD | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY or CREMATORY New Sawyer Creek Cntry. Bellscross, N.C. | |
| 24D. LOCATION (City, town, or county) (State) Bellscross, N.C. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | | |
| 25B. NAME OF REGISTRAR Randolph J. Collick | | 25C. FUNERAL DIRECTOR 2431 E. Oliver St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. | |
|---|-----------------------------------|--|------------------------------------|--|------------------------------|
| 66 09223 | | CERTIFICATE OF DEATH | | 66 09223 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | DAMON, CASSANDRA | | 9-5-66 10 ²⁷ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| JOHNS HOPKINS HOSPITAL | | MD HAGERSTOWN Washington | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | HAGERSTOWN | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1004 LINWOOD RD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| FEMALE | CAU | SINGLE | 07-12-63 | 3 | US |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | HAGERSTOWN | US | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Blythe Damon | | Gloria Bragunier | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | none | Mrs. Gloria Damon, Hagerstown, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 45 MIN | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 8-31-66 | | NEUROGENIC BLADDER | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-23-1966 to 9-5-1966, that (I) (we) last saw the deceased alive on 9-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| burial | | 9/8/66 | | Rose Hill Cemetery | |
| | | | | Hagerstown, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 13 1966 | | Robert E. Taylor, M.D. | | Minnich Funeral Home Hagerstown, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------|--|---------------------------|--|---|
| BIRTH NO. 66 09224 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09224 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLOTTE MAY CLEMENS | | 2. DATE AND HOUR OF DEATH 9-9-66 7:30 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2449 MARYLAND AVE. 21218 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 11-12-07 | 9. AGE (In year, last birthday) 58 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Frederick T. COARD | | 14. MOTHER'S MAIDEN NAME Lottie Lee | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HUSBAND ADDRESS SAME CHARLES M. CLEMENS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Hypertensive Arteriosclerotic Cardiovascular Disease (B) DUE TO Acute Myocardial Infarction (C) | | INTERVAL BETWEEN ONSET AND DEATH ? YEARS 5 DAYS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 7, 1966 to Sept 9, 1966, that (I) (we) last saw the deceased alive on SEPT 9, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James W. Carty, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/9/66 | |
| 23C. PHYSICIAN'S NAME (DR.) JAMES W. CARTY JR. | | 23D. ADDRESS UNION MEMORIAL HOSPITAL, BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/13/1966 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Paul E. Fickens | | 25C. FUNERAL DIRECTOR W.M. J. Richter & Sons | |
| | | | | ADDRESS Balto. Md. north & p. ave. | |



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66 09225

BALTIMORE CITY HEALTH DEPARTMENT

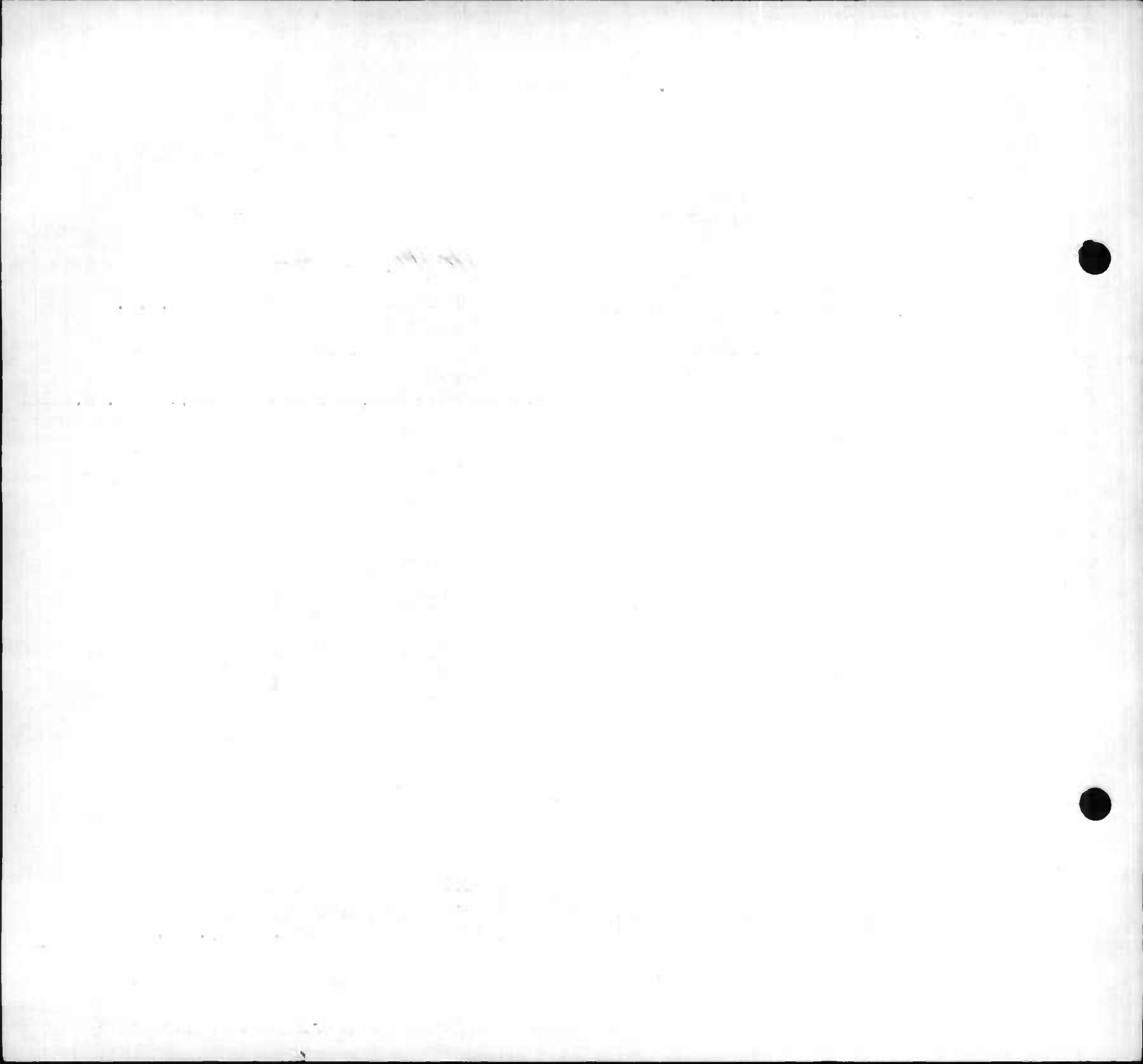
CERTIFICATE OF DEATH

Registered No. 66 09225

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

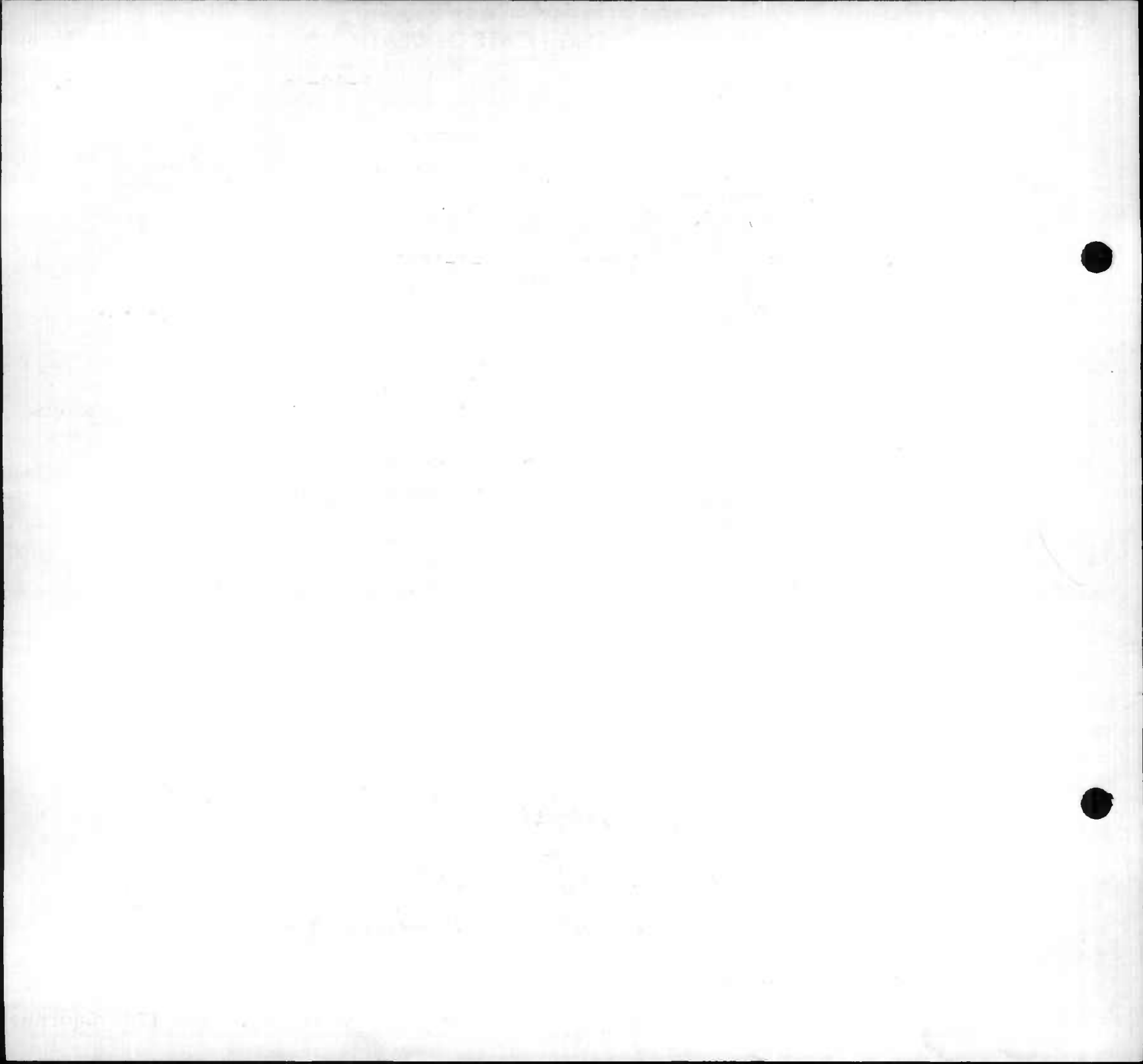
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|--|-------------------------|--|---|
| BIRTH NO. 66 09225 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Lillie Lillian M. TRAYNHAM</i> | | 2. DATE AND HOUR OF DEATH <i>7 AM Sept 10 1966</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i> | | C. CITY OR TOWN (If outside city limits, write BORON and give township) <i>BALTIMORE</i> | |
| | | D. STREET ADDRESS (If rural, give location) <i>2909 WESTWOOD AVENUE - 21216</i> | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>11/07/1912</i> |
| | | 9. AGE (In years last birthday) <i>54</i> | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>BOTTS, WILLIE</i> | | 14. MOTHER'S MAIDEN NAME <i>, SADIE</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>214-24-3485</i> | |
| 17. INFORMANT <i>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</i> | | ADDRESS | |
| 18. I <i>170X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Adenocarcinoma / heart</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | |
| INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-15-66</i> 19 to <i>9-10-66</i> 19 that (I) (we) last saw the deceased alive on <i>9-9-66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>V. J. Felitti</i> | | 23B. DATE SIGNED <i>9-10-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>V. J. Felitti</i> | | 23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Balto. Md. 21224</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9-14-66</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>MT. Auburn</i> | | 24D. LOCATION <i>BALTO, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fairman</i> | |
| 25C. FUNERAL DIRECTOR <i>MORTON & DYER</i> | | ADDRESS <i>1701 LAURENS ST.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

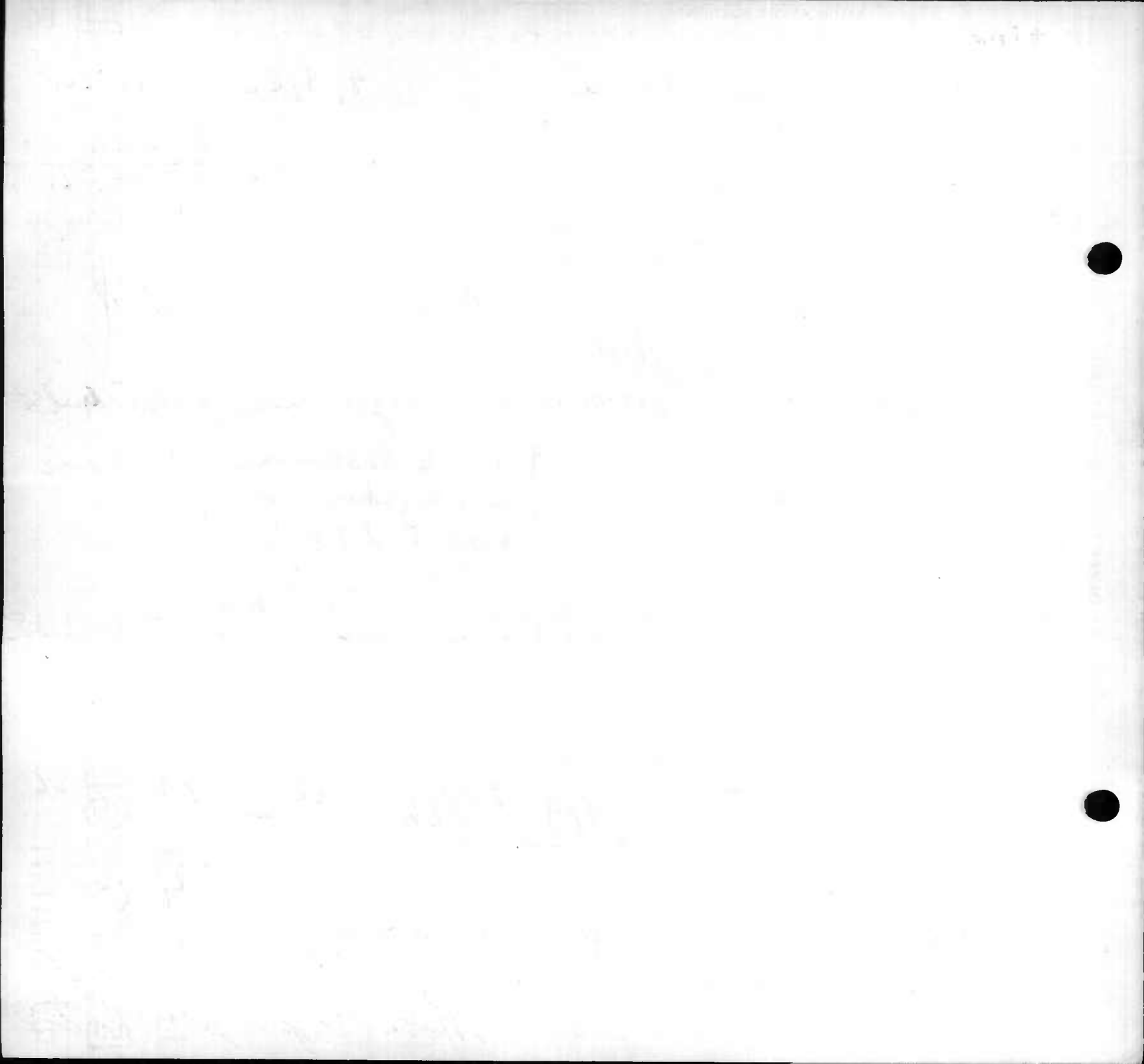
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|--|---|---|---|---|--|
| BIRTH NO. 66 09226 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09226 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Luvenia Brown | | 9-10-66 9:00 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home 27 N. Carey Street Baltimore, Md. 21223 | | A. STATE Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1321 Eutaw Place | | | |
| 5. SEX F. | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-3-1903 | 9. AGE (In years last birthday) 62 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Records: Lincoln Nursing Home | |
| 18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH CARCINOMA OF UTERUS WITH METASTASIS | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | |
| | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/19/65 19 to 9/10/66 19 that (I) (we) last saw the deceased alive on 9/10/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | 23B. DATE SIGNED 9/14/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE | | 23D. ADDRESS 93 WHITELOCK ST, BALT. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY or CREMATORY MT CALVARY | |
| | | | | 24D. LOCATION (City, town, or county) (State) AA. Co Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett Fun. Home 1701 Laurens | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|---|--|---|
| BIRTH NO. 66 09227 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09227 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Taylor, Flora | | | 2. DATE AND HOUR OF DEATH 9/9/66 11:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-05 D. STREET ADDRESS (If rural, give location) 326 EAST FEDERAL STREET | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 1887 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Hill | | 11. BIRTHPLACE (State or foreign country) Mass. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-05-0183 | | 17. INFORMANT Mary Addison | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable Azotemia | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. also CVA | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Dehydration, malnutrition, azotemia, septic urinary tract infection | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8 19 66 to 9/9 19 66 , that (I) (my) last saw the deceased alive on 9/9 19 66 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE David S. Fedson | | | | 23B. DATE SIGNED 9/9/66 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID S. FEDSON | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/12/66 | | 24C. NAME of CEMETERY or CREMATORY Mt Calvary | |
| 24D. LOCATION AA Co. Maryland | | 24E. LOCATION AA Co. Maryland | | 24F. LOCATION AA Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR James E. Fairley | | 25C. FUNERAL DIRECTOR Michael A. Jones Jr. | |
| 25D. ADDRESS 1735 Bayfield Ave | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09228 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09228 | |
|--|------------------|---|-----------------------------|---|-----------------------------|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) KING, JR., WALTER, E. | | | | 2. DATE AND HOUR OF DEATH 9-11-66 5:40AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVE. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 D. STREET ADDRESS (If rural, give location) 526 BRISBANE RD. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH 3-24-09 | 9. AGE (In years last birthday) 57 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X-RAY ENGR. | | 10B. KIND OF BUSINESS OR INDUSTRY STANDARD X-RAY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA (NORFOLK) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALTER KING | | | | 14. MOTHER'S MAIDEN NAME MABEL HOWARD | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2 | | 16. SOCIAL SECURITY NO. 237-18-1196 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS WILKENS & CATON AVE. BALTIMORE, MD. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-18 19 66 to 9-11 19 66, that (I) (we) lost saw the deceased alive on 9-11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. JUAN CABRERA JUAN J. CABRERA | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 Robert E. Fairley | | | | 25B. NAME OF REGISTRAR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 66 09229 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09229 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SAMUEL STOKES | | | 2. DATE AND HOUR OF DEATH 9-5-66 9:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP OF MD. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2801 Raynor Ave 16-06 | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID. | 8. DATE OF BIRTH 9-5-88 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) USA Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Frank H Stokes | | | 14. MOTHER'S MAIDEN NAME Annie | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W1-1917 | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Evelyn Shields 2547 Arundel Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I CAUSE OF DEATH (A) MALIGNANCY OF THE LUNG (B) Chronic (C) INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA, TERMINAL | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-5-1966 to 9-5-1966 , that (I) (we) last saw the deceased alive on 9-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Renato R. Espina M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-5-66 | |
| 23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA M.D. | | | | 23D. ADDRESS LUTHERAN HOSP OF MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-9-66 | | 24C. NAME OF CEMETERY or CREMATORY Balto National Cem Balto Md | |
| 24D. LOCATION (City, town, or county) (State) Balto Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | | |
| 25B. NAME OF REGISTRAR Rayner Sanders | | 25C. FUNERAL DIRECTOR 217 E Preston St | | | |

AMERICAN TANK

1
M-536

66 09230

BALTIMORE CITY HEALTH DEPARTMENT

66 09230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Catherine Minter

2. DATE AND HOUR PRONOUNCED DEAD

9/5/66 8:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2133 McCulloh St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2133 McCulloh St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11-21-1925

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Minter

14. MOTHER'S MAIDEN NAME

Polly Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Sylvia Jones 2640 Boone St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/6/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-10-66

23C. NAME OF CEMETERY or CREMATORY

St. Calvary Cem. A. A. Co

23D. LOCATION

(City, town, or county)

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

SEP 13 1966

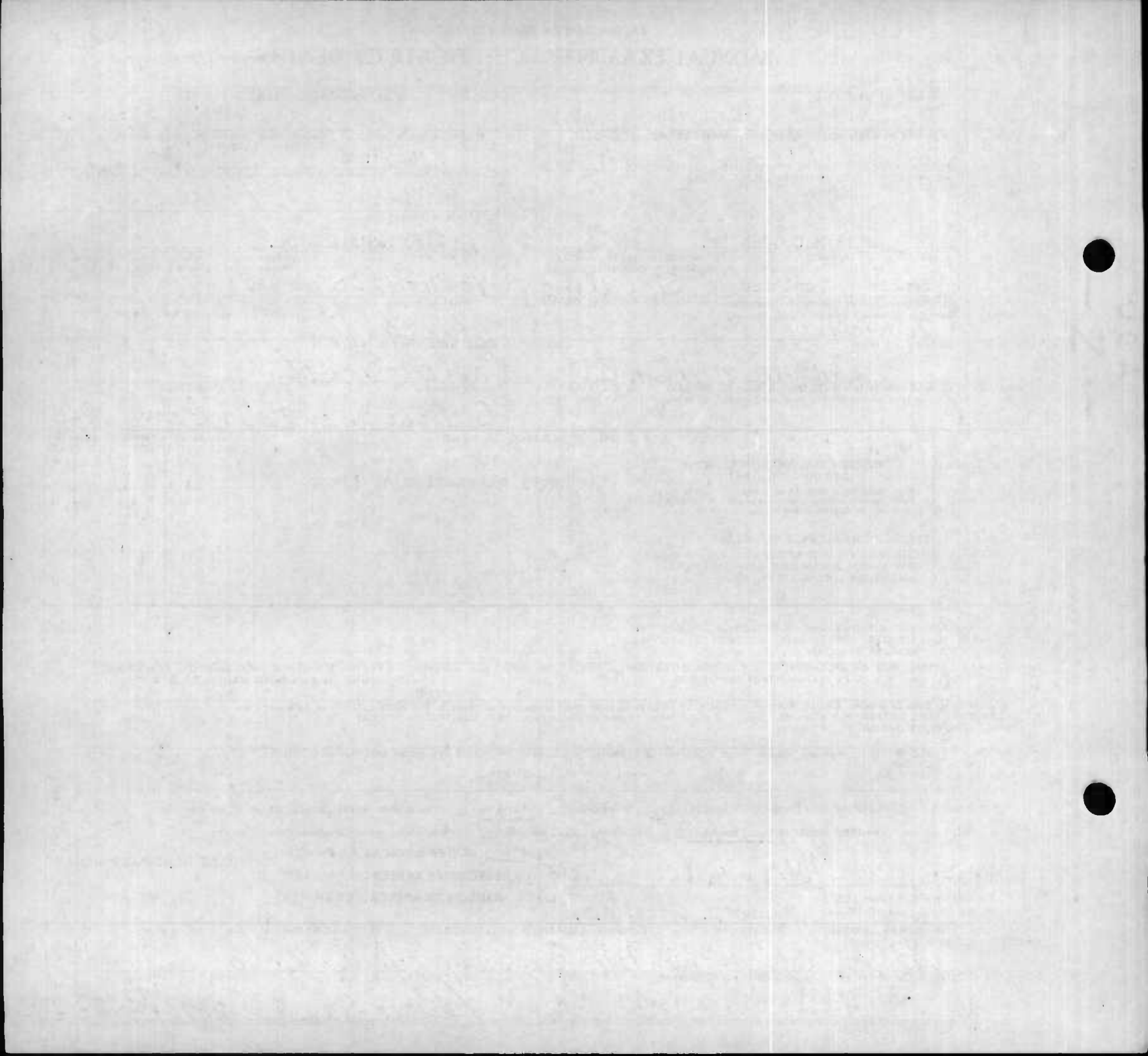
24B. NAME OF REGISTRAR

R. E. Faldut

24C. FUNERAL DIRECTOR

Rayner Sanders 2176 E. Preston St

ADDRESS

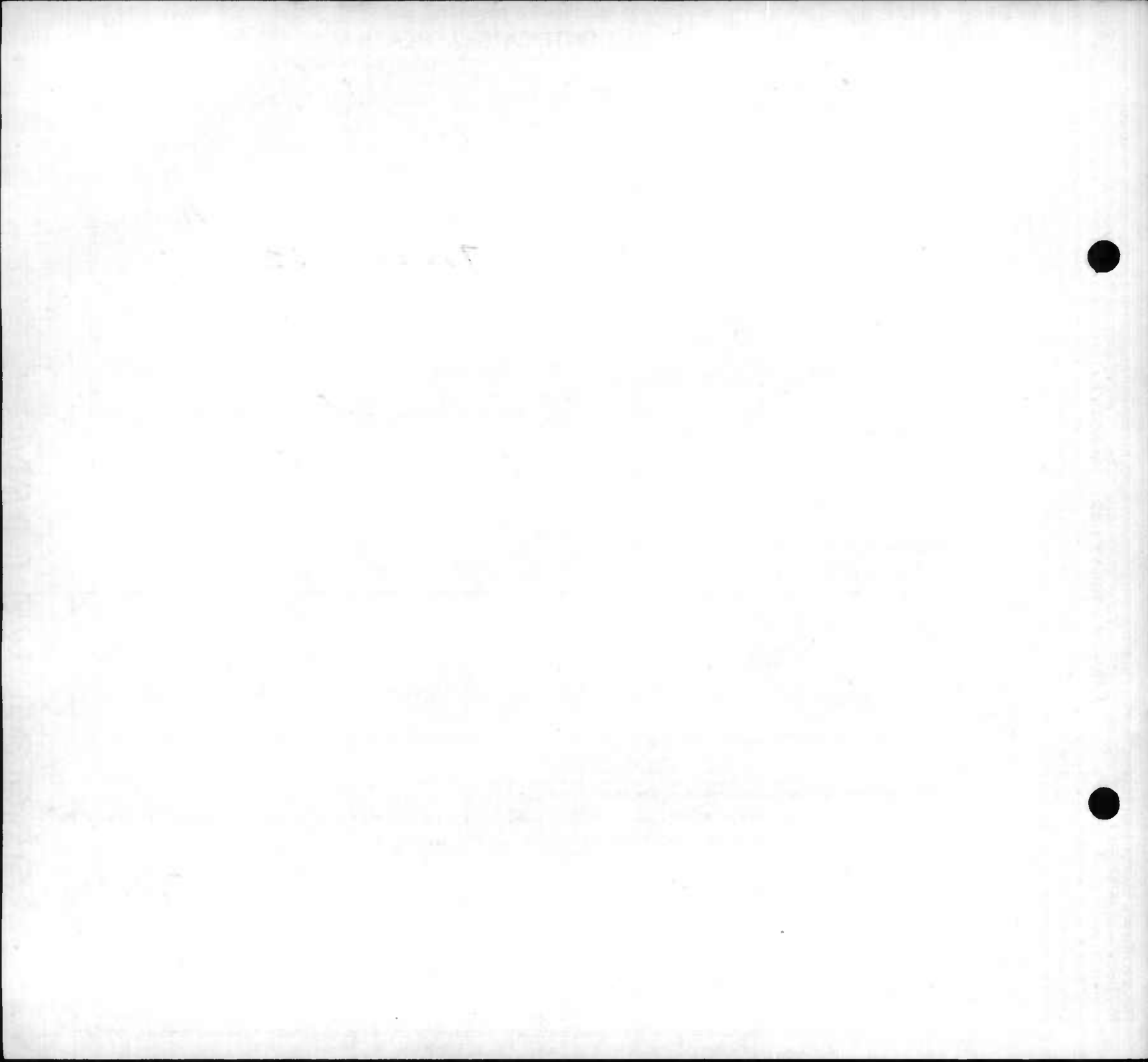


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|--|--|---|
| BIRTH NO. 66 09231 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09231 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Aaron Douglass</i> | | | 9/12/66 10 ⁵² A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIV. HOSP.</i> | | | A. STATE <i>Md.</i> B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 17-03</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>831 Harlem Ave.</i> | | |
| 5. SEX <i>M</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>?</i> | 8. DATE OF BIRTH <i>9/15/03</i> | 9. AGE (In years last birthday) <i>62</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>?</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>?</i> | 11. BIRTHPLACE (State or foreign country) <i>North Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>?</i> | | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i> | | 16. SOCIAL SECURITY NO. <i>240-07937</i> | 17. INFORMANT ADDRESS <i>Annie Jackson Same</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>16211 I</i> | | | CAUSE OF DEATH (A) <i>Bronchogenic Ca</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>J. Seeger</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/12/66</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>J. SEEGER</i> | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i> | | 24B. DATE <i>9-12-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt Airy Cem</i> | |
| | | 24D. LOCATION (City, town, or county) (State) <i>Balto Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John E. Fadden</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Thoy C. Wilson 1000 Brantley Ave</i> | |

SEP 13 1966



BIRTH NO.

66 09232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09232

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Fanny

HARPER

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1966 6:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1919 Sherwood Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

6 mts.

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Chemical pneumonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Ingestion and aspiration of
insecticide containing diazinon

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Home of Grandmother

1918 Hope Street, Baltimore 21218

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 10 '66 10:50 AM.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingested insecticide containing diazinon

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9-14-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 13 1966

R. E. Fairley, M.D.

Choy Wilson M.B. Brantly

Birth date not on history sheet - 9-15-66

B-520

66 09233

BALTIMORE CITY HEALTH DEPARTMENT

66 09233

BIRTH NO. *North Carolina*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|---------------------|--|---|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) James T. Banks | | | | 2. DATE AND HOUR PRONOUNCED DEAD 9-9-66 4:55 p.m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home Hospital DOA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-04 D. STREET ADDRESS (If rural, give location) 221 N. Durham St. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Child</i> | 8. DATE OF BIRTH 8-17-61 | 9. AGE (In years last birthday) 5 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>North Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>James McJee Banks</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Carol McJee</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Carol Banks</i> | | ADDRESS <i>Same</i> | |
| 18. CAUSE OF DEATH Multiple severe injuries (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 9-9-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fayette St. east of Ann St. 5-01 | | |
| 21D. TIME OF INJURY (APPROX.) 9-9-66 4:45 p | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Pedestrian struck by car | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-10-66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i> | | 23B. DATE 9-15-66 | | 23C. NAME OF CEMETERY or CREMATORY <i>New Cent. MC</i> | | 23D. LOCATION (City, town, or county) (State) <i>Emmell N. Carolina</i> | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR <i>Robert E. Jackson, JR.</i> | | 24C. FUNERAL DIRECTOR <i>Branch Home N. Carolina</i> | | | |

SEP 13 1966

WALLER OFFICE

10-11-01

Jul

10-11-01

James J. Waller

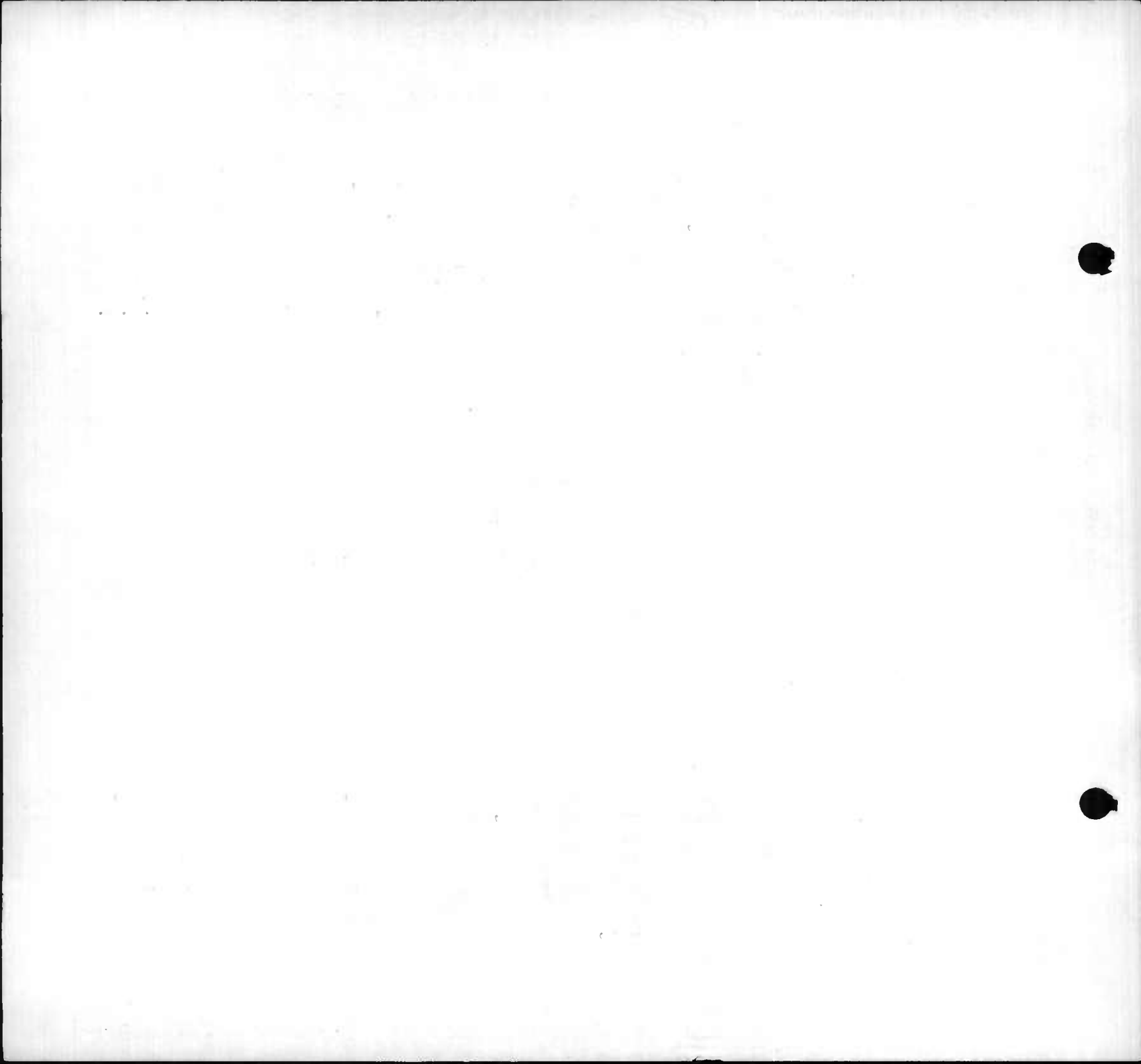
10-11-01

James J. Waller
10-11-01

FUNERAL DIRECTOR: IMPORTANT

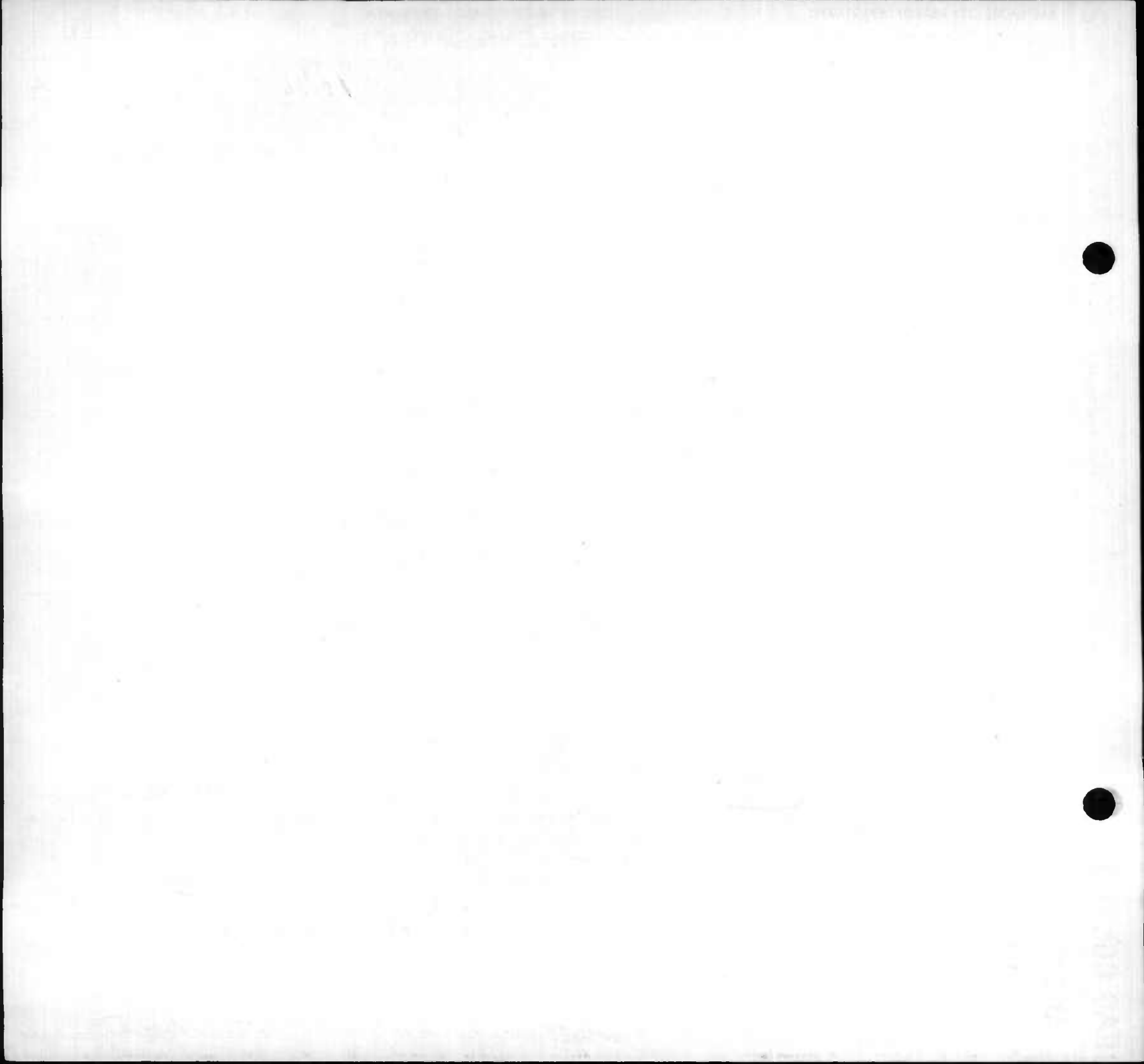
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09234 | |
|---|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09234 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ruth Holmes (Butler) Glasco | | 2. DATE AND HOUR OF DEATH 9-11-66 1:20 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1101 N. Gilmore Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-7-16 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Malachi Butler | | 14. MOTHER'S MAIDEN NAME Storace Anderson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. George Holmes (husband) Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Intestinal Obstruction | | CAUSE OF DEATH (A) Acute Intestinal Obstruction (B) Uremia (C) Chronic Pyelonephritis | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 7, 1966 to September 11, 1966 , that (I) (we) last saw the deceased alive on September 11, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Malabrigo | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) Joel Malabrigo, | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-15-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1966 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS Calvin W. Wilson 1001 Brandy | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 09235</u> | |
|--|-----------------------|--|--|--|--|--|--|
| W-4512 | | 66 09235 | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Betty Williams</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/20/66</u> <u>5:00 AM</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-02</u> D. STREET ADDRESS (If rural, give location) <u>1318 - Harlem Ave.</u> | | | |
| 5. SEX <u>Fe.</u> | 6. RACE <u>Negroe</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>4/12/25</u> | 9. AGE (In years last birthday) <u>41</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Richard Harris</u> | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>219-14 2250</u> | | 17. INFORMANT <u>Robert Blackmon</u> | | ADDRESS |
| 18. <u>442X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Arteriole nephrosclerosis</u> <u>HA SCVD</u> | | | | CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Arteriole nephrosclerosis</u> DUE TO (C) <u>HA SCVD</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congestive Heart Failure</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>July 27</u> , 19 <u>66</u> to <u>September 10</u> , 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>September 10</u> , 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Robert C. Blackmon</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/10/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackmon</u> | | | | 23D. ADDRESS <u>Lutheran Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u> | | 24B. DATE <u>9-14-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cor</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Feltner</u> | | 25C. FUNERAL DIRECTOR <u>Choy G. Wilson</u> | | ADDRESS <u>1000 Bramley Ln</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

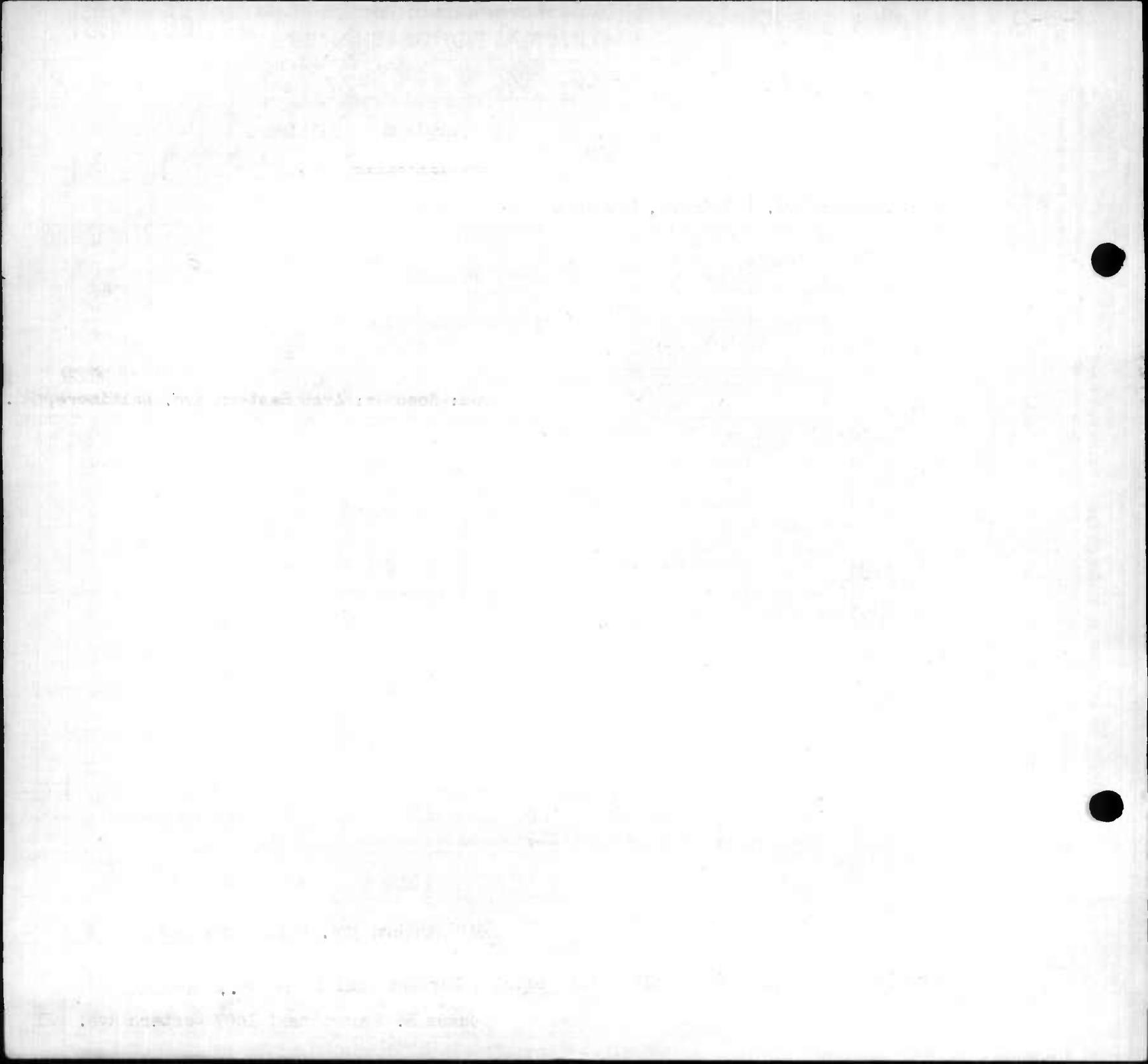
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09236 | |
|--|---------------------|--|-----------------------------------|---|--|
| BIRTH NO. 66 09236 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MRS. MARGUERITE MONAHAN | | 2. DATE AND HOUR OF DEATH 9/11/66 10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 2025 W. Fayette St. Baltimore 23, Md. | | D. STREET ADDRESS (If rural, give location) 1210 W. Lombard St. # 23, Md. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/6/97 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Plastics | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Robert Pfeiffer | | 14. MOTHER'S MAIDEN NAME O'Brien | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | 16. SOCIAL SECURITY NO. 216-03-3221 | | 17. INFORMANT Thomas P. Monahan | |
| 18. ADDRESS 1210 W. Lombard St | | 19. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Arteriosclerotic Heart Disease | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 9/11/66 3:05 AM 19 66 to 9/11/66 19 66 , that (I) (we) last saw the deceased alive on 9/11/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL BRATHIN | | 23D. ADDRESS Balto Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem | |
| 24D. LOCATION (City, town, or county) (State) Balto Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Thomas J. Korney Inc | | ADDRESS Balto Md | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

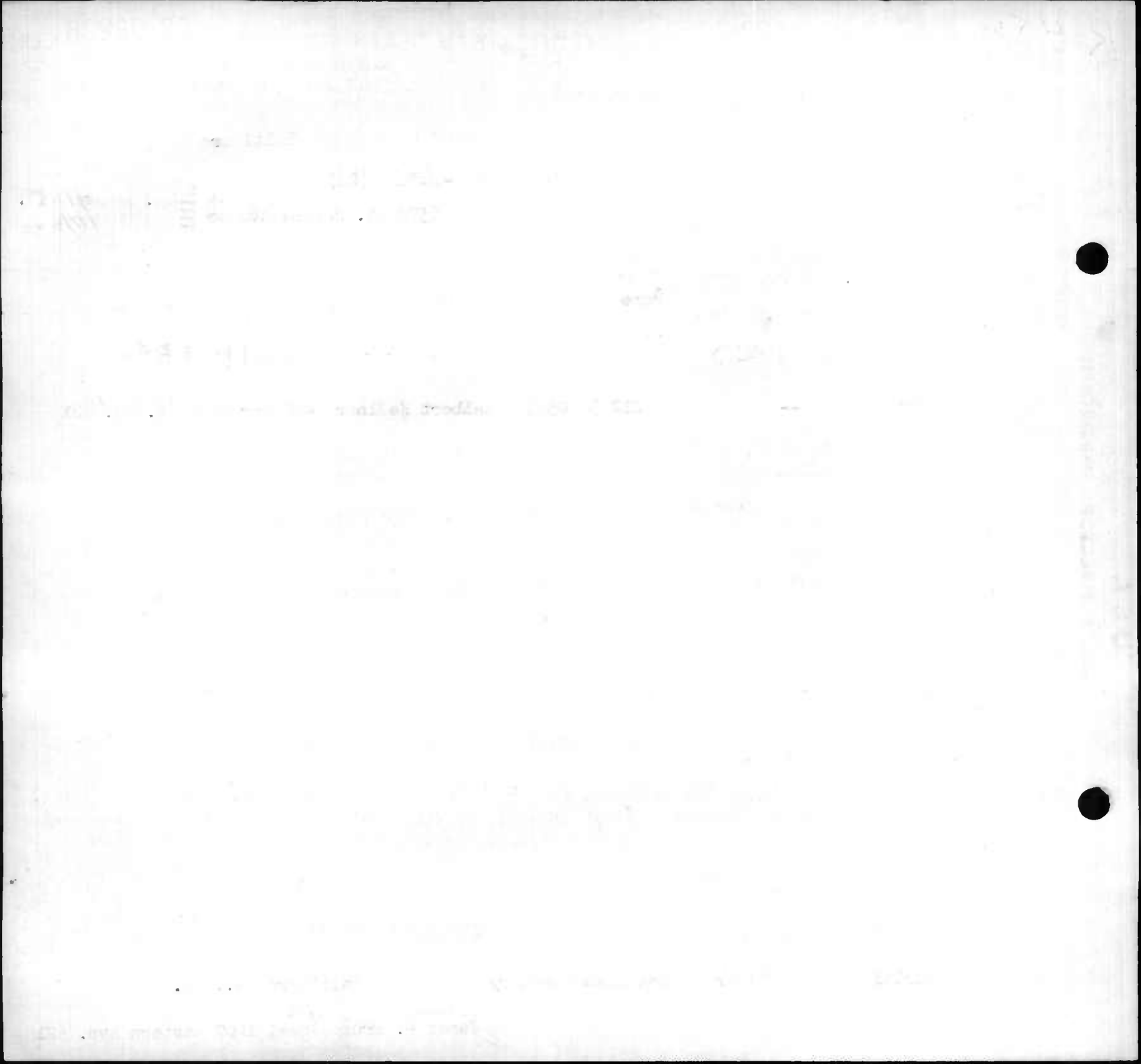
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|---|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09237 | | | | |
| BIRTH NO. 66 09237 M.E. CASE NO. 66-00013 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HARDESTY, Flora M. | | | | | 2. DATE AND HOUR OF DEATH 9/11/66 11:00 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) # 21224 BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland | | | | | A. STATE Maryland B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore ESSEX (21221) 5300 | | | | |
| D. STREET ADDRESS (If rural, give location) 1414 Sussex Rd. | | | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married | | 8. DATE OF BIRTH 1-3-66 | 9. AGE (In years last birthday) - | 10. Under 1 Yr. Months: 8 Days: 8 | | 11. Under 24 Hrs. Hours: - Min: - | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME William Hardesty | | | | | 14. MOTHER'S MAIDEN NAME Alice Peyton | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT BCH: Records: 4940 Eastern Ave. Baltimore, Md. | | | | |
| 18. 571.01 CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) Dehydration DUE TO | | | | |
| | | | | | (B) Gastroenteritis DUE TO | | | | |
| | | | | | (C) Possible Sepsis DUE TO | | | | |
| 19. DATE OF OPERATION 2 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No) YES | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 1966 to 9/11 1966, that (I) (we) last saw the deceased alive on 9/11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Julio Zavala | | | | | 23B. DATE SIGNED 9/11/66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Julio Zavala | | | | | 23D. ADDRESS Baltimore City Hospitals, Bldg. Md. 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | | 24C. NAME OF CEMETERY or CREMATORY Holly Hill Memorial Gardens Baltimore Co. Maryland | | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | 25B. NAME OF REGISTRAR James E. Brundzinski | | | 25C. FUNERAL DIRECTOR James E. Brundzinski 1407 Eastern Ave. #21 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 66 09238 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09238 | |
| 1. NAME OF DECEASED (Type or Print) MRS ALVERTA A. KELLNER | | | 2. DATE AND HOUR OF DEATH September 10, 1966 12 noon M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk (22) D. STREET ADDRESS (If rural, give location) 6578 St. Helena Avenue | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED | 8. DATE OF BIRTH 2/11/38 | 9. AGE (In years last birthday) 28 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - > BABY SITTER | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME RALPH WELTY | | |
| 14. MOTHER'S MAIDEN NAME LEONA WHITE | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | |
| 16. SOCIAL SECURITY NO. 212 36 0543 | | | 17. INFORMANT ADDRESS Albert Kellner 480 Barrison Pt. Rd. #21 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS 2(?) MUCOCARDIAL INFARCTION BILE PERITONITIS | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/17/1966 to Sept 10 1966 , that (I) (we) lost saw the deceased alive on Sept. 10 1966 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel J. Tan M.D. | | | | 23B. DATE SIGNED Sept. 10/66 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN | | | | 23D. ADDRESS CHURCH HOME & HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION Baltimore Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR James L. Brudzinski | | | |
| 25D. ADDRESS 1407 Eastern Ave. #21 | | | | | |



66 09239

BALTIMORE CITY HEALTH DEPARTMENT

66 09239

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES S. HITE

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1966 8:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

10-21-66

1312 Riggs Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1312 Riggs Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BOOKSTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Brunswick Ga

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES HITE

14. MOTHER'S MAIDEN NAME

MARY HITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ann Brown 31 Bernice St

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Alcoholic Cardiomyopathy

Laennec's Cirrhosis

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Laennec's Cirrhosis

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/8/66

23A. BURIAL CREMATION,
REMOVED (Specify)

23B. DATE

9/12/66

23C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Baltimore P. Taylor 638 N. Gilmor St

ADDRESS

Letter from M.E.'s office

10-21-66

M.H.

Smile

abuse
Chances 14-16

no

Prisoner's Cell 1114

Monthly

Mr. [unclear] 31 [unclear]

10-21-66
[unclear] [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09240

BIRTH NO. 66 09240

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Green, Joseph

2. DATE AND HOUR OF DEATH

9-12-66

830 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lincoln Memorial Nursing Home
27 N. Carey St.
Baltimore, Md. 21223

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

309 N. Mount Street

5. SEX

M

6. RACE

N

7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/10/93

9. AGE (In years lost birthday)

73

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Green

14. MOTHER'S MAIDEN NAME

REBECCA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-12-7638

17. INFORMANT

Ray Green 309 N Mount St

ADDRESS

18. 493 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Vascular Accident (old)

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 6 1966 to Sept. 12 1966, that (I) (we) last saw the deceased alive on Sept. 11. 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Annis Tennant

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

9-12-66

23C. PHYSICIAN'S NAME (Type)

Annis Tennant

M.D.

23D. ADDRESS

930 WHITELOCK ST BALT

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/12/66

24C. NAME OF CEMETERY or CREMATORY

West Avenue

24D. LOCATION (City, town, or county) (State)

Baltimore

25A. DATE REC'D BY HEALTH DEPT.

SEP 14 1966

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Man... 635 N York

ADDRESS

John W. ...

John W. ...
...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. 66 09241 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09241 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) KNUCKLES, MYRTLE E | | 2. DATE AND HOUR OF DEATH 9/12/66 9:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY 2001 | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND HOSPITAL | | D. STREET ADDRESS (If rural, give location) 1812 LAURETTA AVE. | | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JAN. 10, 1910 | 9. AGE (In years last birthday) 56 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-LAUNDRY | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME LUZIE CAMP | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS HOSPITAL CHART. + HUSBAND | |
| 18. 224X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) PULMONARY INFARCT DUE TO (B) PHEOCHROMOCYTOMA DUE TO (C) PHEOCHROMOCYTOMA | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 8/31/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PHEOCHROMOCYTOMA | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> NONE | | 21F. HOW DID INJURY OCCUR? NONE | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/1/66 19 66 to 9/12 19 66 , that (I) (we) last saw the deceased alive on 9/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Brent C. Sanders | | | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) BRENT C. SANDERS | | 23D. ADDRESS 137 NORTH BEND ROAD #2C | | BALTIMORE MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY or CREMATORY GAFFNEY S.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Sanders | | 25C. FUNERAL DIRECTOR Marshall Phelps 638 N. G. corner st | |

Unknown

Remains of the

Century 2.C

Remains of the

1
D. 620

66 09242

BALTIMORE CITY HEALTH DEPARTMENT

66 09242

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William D. Dorsey

2. DATE AND HOUR PRONOUNCED DEAD

9-9-66

4:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland penitentiary

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO 21223

D. STREET ADDRESS (If rural, give location)

1506 VINE ST

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

12-1-1926

9. AGE (In years last birthday)

39

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PROFESSOR

10B. KIND OF BUSINESS OR INDUSTRY

Dry Cleaners

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm F Dorsey

14. MOTHER'S MAIDEN NAME

BERTINA HARDMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES WWII

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Wm F Dorsey 1506 VINE ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Perforated gastric ulcer DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-10-66

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/14/66

23C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION (City, town, or county)

Balto Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 14 1966

Wm F E. Taylor, M.D.

Man Gann R. Hays

James M. Miller
James M. Miller

yes with
Wm. K. Dorey
Professor J. J. Clements
Berkman Hargrave
1/15

Since
15-1-1882

1200 Nov 14
1200 Nov 14

and

66 09243

BALTIMORE CITY HEALTH DEPARTMENT

66 09243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James William Johnson

2. DATE AND HOUR PRONOUNCED DEAD

9-10-66

2:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1503 W. Lanvale St.

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

2-9-1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CONTRACT

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM HAMILTON

14. MOTHER'S MAIDEN NAME

IRMA JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-32-0545

17. INFORMANT

ADDRESS

IRMA JOHNSON 1926 LANVALE ST

18.

E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Corner of Calhoun St. and Riggs Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-10-66 2:15 a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9/14/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

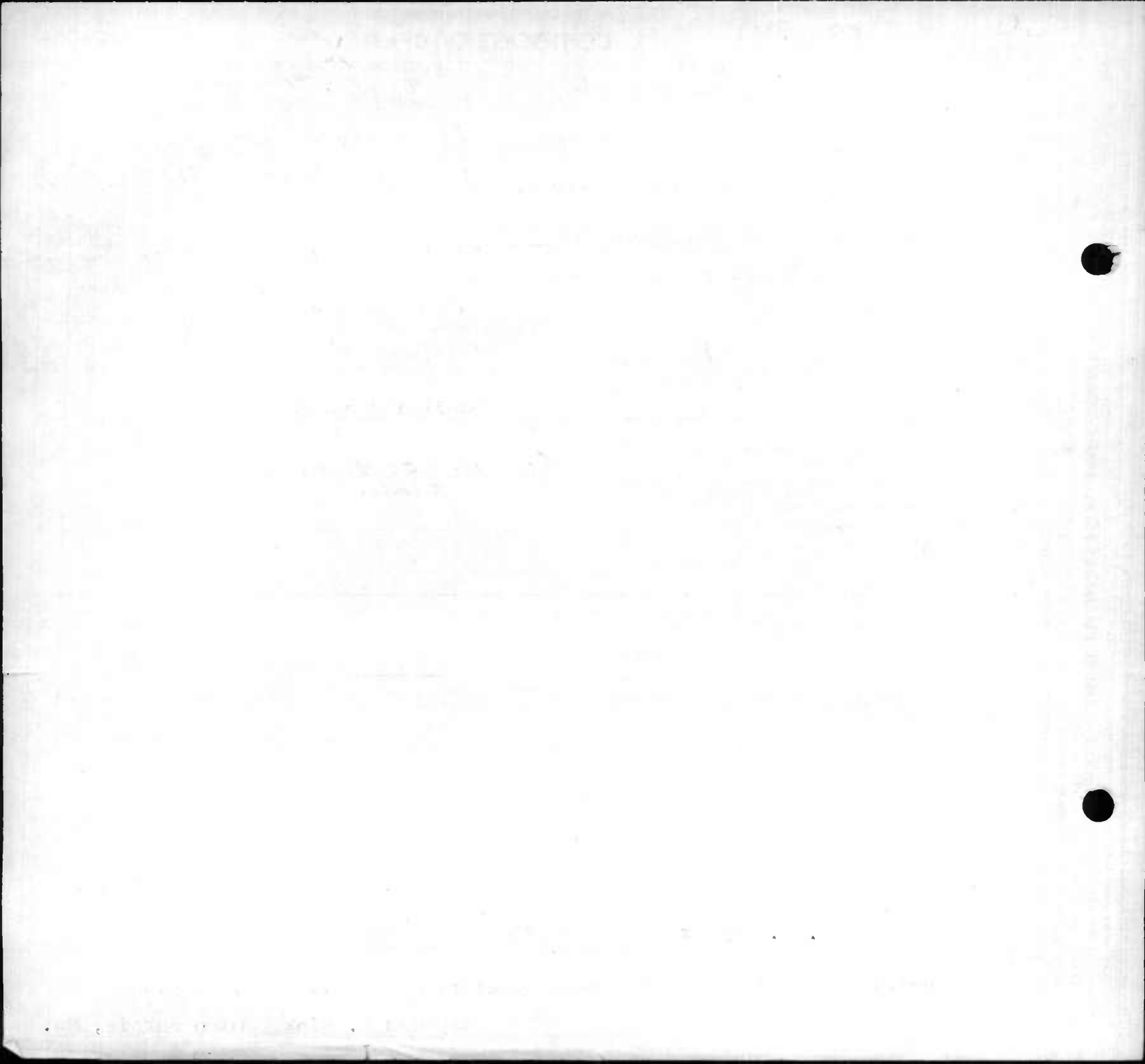
ADDRESS

Margaret D. Hayes 638 N. Calver St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

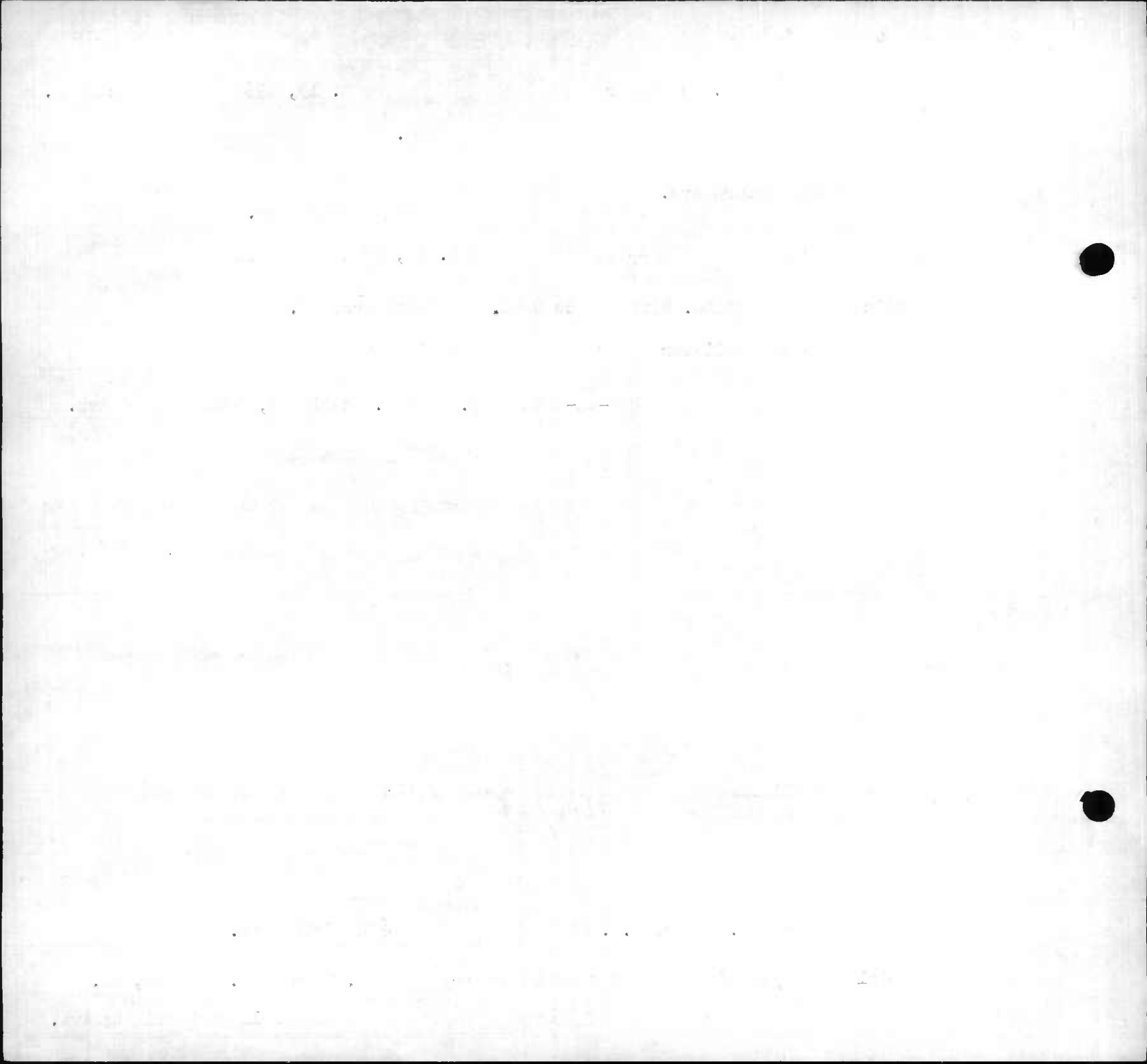
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09244</u> | |
|--|------------------|---|-----------------------------------|---|---|
| BIRTH NO. <u>66 09244</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>66-18528</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Joanna H. Barbara Bento</u> | | 2. DATE AND HOUR OF DEATH <u>8:57 AM 9/12/66</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIV. HOSP, BALTIMORE</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>94</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linthicum Hts. 21090 52-00</u> D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>9/2/66</u> | 9. AGE (In years last birthday) <u>10</u> | If Under 1 Yr. Months Days <u>10</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u> | |
| 13. FATHER'S NAME <u>Jesse J. Bento</u> | | 14. MOTHER'S MAIDEN NAME <u>Barbara, Wear</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Hospital Records</u> ADDRESS | |
| 18. <u>734.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CONGENITAL ACYANOTIC HEART DISEASE</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. F. Seegar</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/12/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. F. Seegar</u> | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/13/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Raymond C. Fink</u> ADDRESS <u>Glen Burnie, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

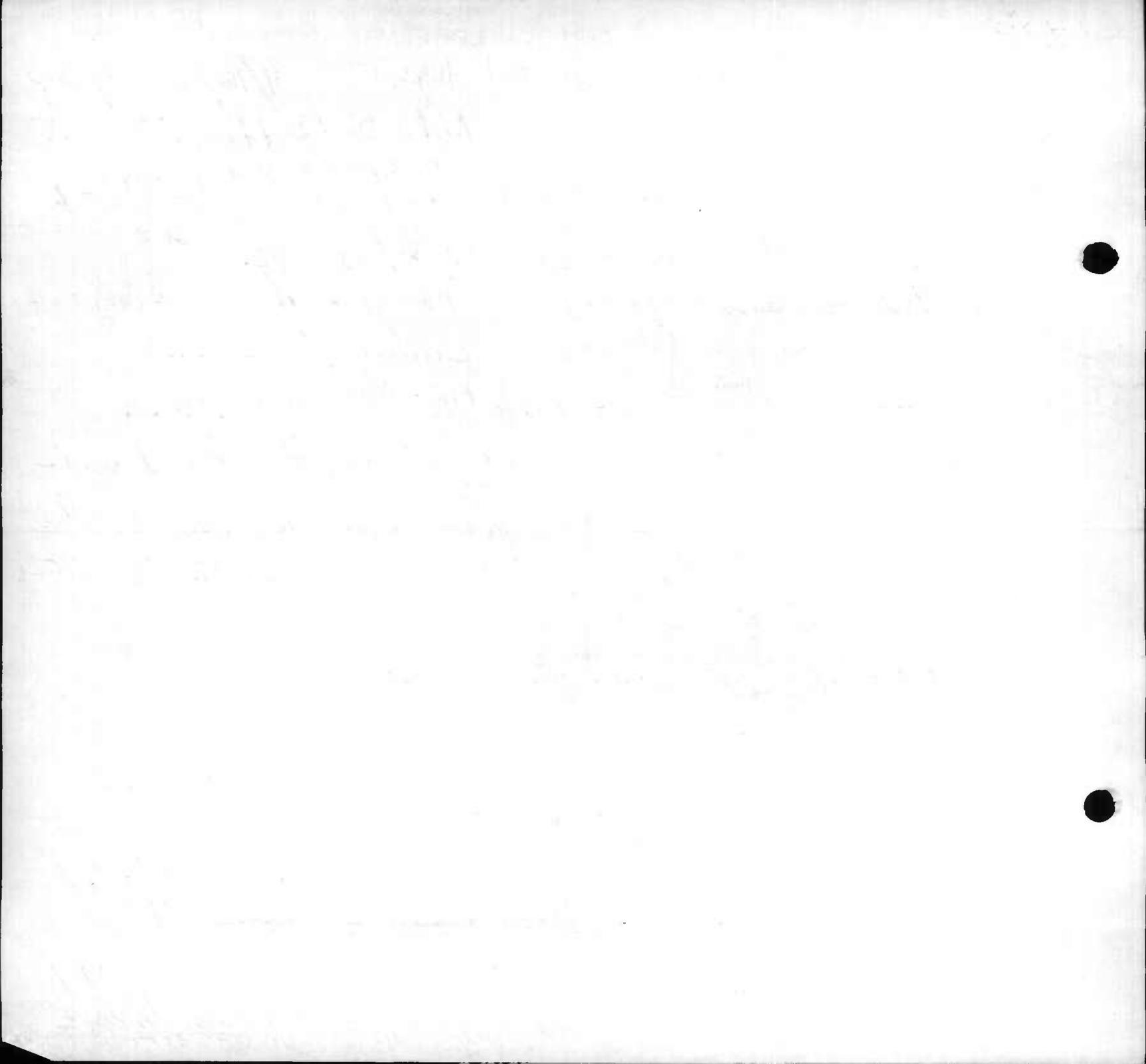
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 09245 | |
|--|---------|--|------------------|--|------------------------------|--|--|
| BIRTH NO. 66 09245 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | John H. McAlister | | Sept. 13, 1966 2:20 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 3102 Oakford Ave. | | | | Md. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3102 Oakford Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. | |
| Male | White | Married | Sept. 13, 1894 | 72 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Police | | Balto. City Police Dept. | | Baltimore, Md. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John McAlister | | | | Bertie Louise Speed | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | 220-44-2042 | | Mr. John H. McAlister, 3102 Oakford Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | 2 days | |
| | | | | (B) DUE TO | | about 3 years | |
| | | | | (C) DUE TO | | about 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 1962-1966 | | Cancer of colon - distal | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1966 19 to September 1966, that (I) (we) last saw the deceased alive on 9/12/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Louis R. Maser | | | | | | 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Louis R. Maser, M.D. | | | | 2724 Smith Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/15/66 | | Mount Carmel Cemetery | | Mt. Carmel Rd. Herford, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 14 1966 | | Robert E. Taylor, M.D. | | B. Vernon Zimmerman | | 4611 Park Heights Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

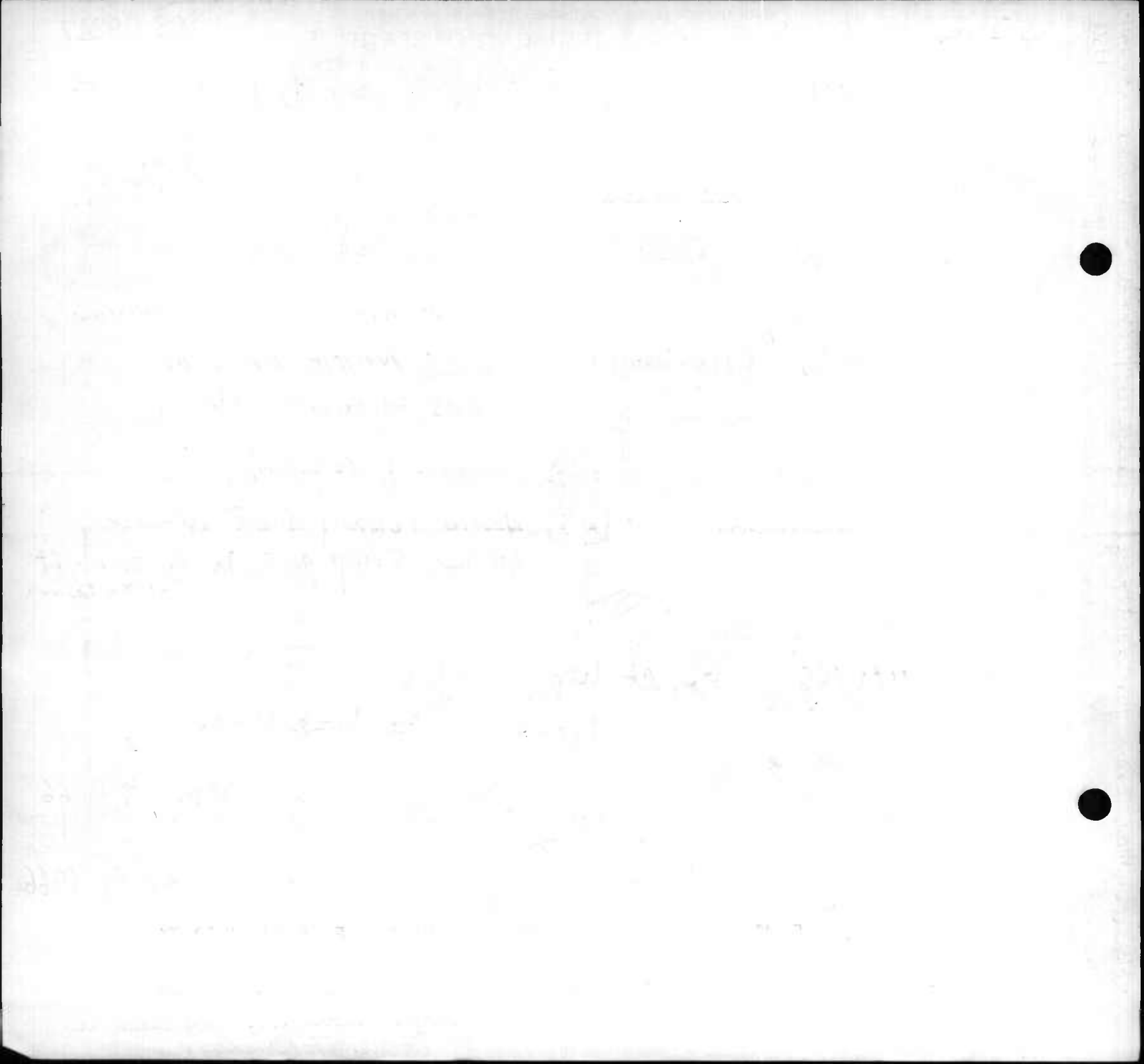
| | | | | | |
|---|---------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09246 | | CERTIFICATE OF DEATH | | Registered No. 66 09246 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GILMORE, ALLEN ANDREW | | 2. DATE AND HOUR OF DEATH 9/10/66 9:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21211 1306 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 803 Wallington Street | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 7/8/92 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENG | | 10B. KIND OF BUSINESS OR INDUSTRY CANNERY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? # AMER. CA. | | 13. FATHER'S NAME Joseph Gilmore | | 14. MOTHER'S MAIDEN NAME Emma ? Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give way or dates of service) No | | 16. SOCIAL SECURITY NO. 213-14-2568 | | 17. INFORMANT ADDRESS Mrs Mrs John Gilmore same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 570.51 | | CAUSE OF DEATH (A) DUE TO Coronary Heart Failure (B) DUE TO Aspiration pneumonia (C) DUE TO Intestinal obstruction | | INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks 3 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/8/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction | | 20A. AUTOPSY? (Yes or No) No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/27/66 19 to 9/10/66 19, that (I) (we) lost saw the deceased alive on 9/10/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Goodman | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) Goodman | | 23D. ADDRESS Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 15 Sept 66 | | 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK CEM. | |
| 24D. LOCATION (City, town, or county) (State) BALTO. County Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS BURGER FUNERAL HOME Lynn Burger 3631 Falls Road | | | |



Released by med. Exam. for Autopsy. To be approved by Medical Examiner. Hsu 9-10-66. FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

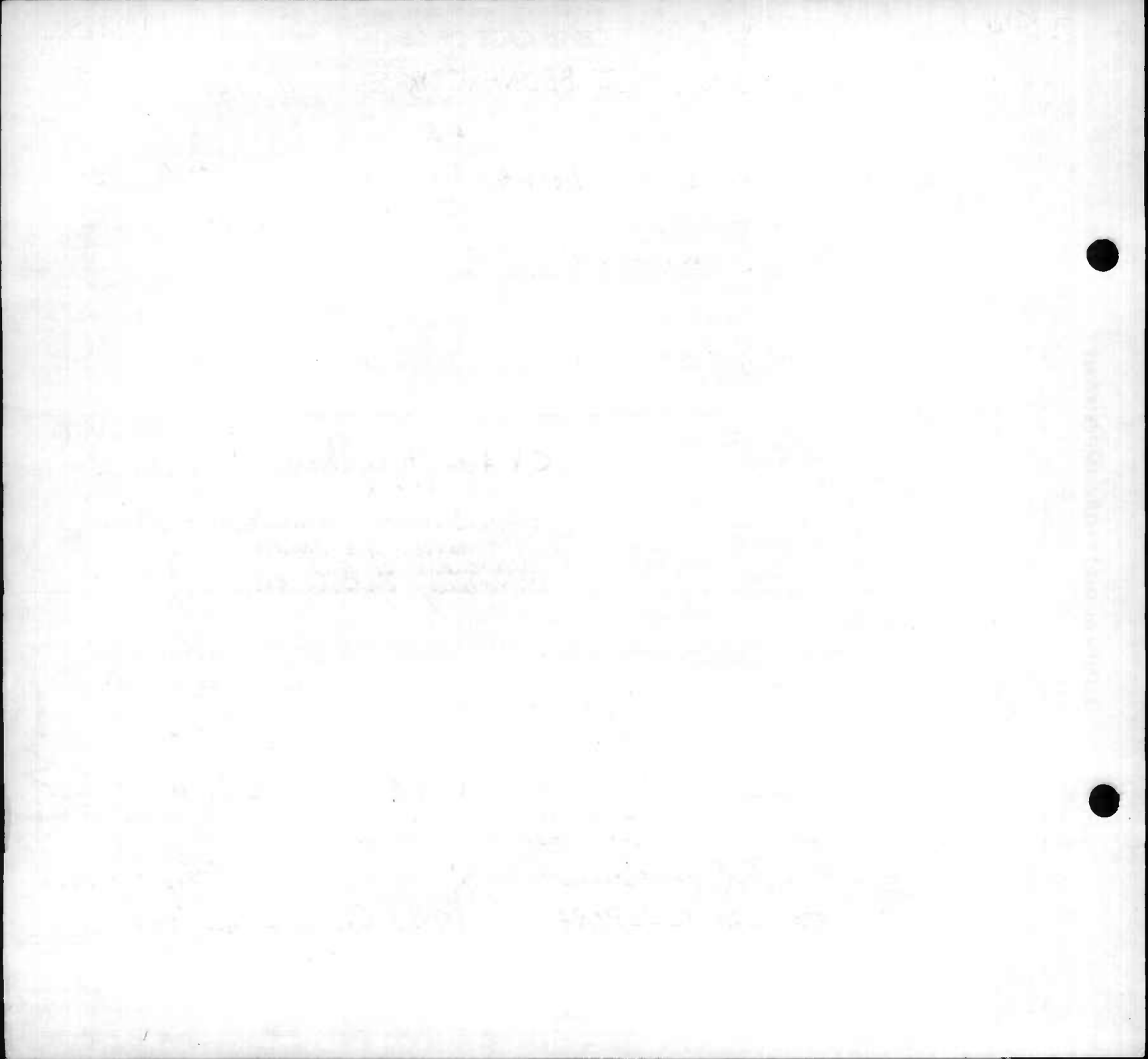
| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 66 09247 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09247 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JULIA P. CUNNINGHAM | | 2. DATE AND HOUR OF DEATH Sep. 9, 1966 4:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | | A. STATE Md. | | B. COUNTY | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 10/30/80 | |
| 13. FATHER'S NAME Jacob Bosch (Germany) | | 14. MOTHER'S MAIDEN NAME ? Nettie Krumm | | 9. AGE (In years, months, days) 80 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 17. INFORMANT Miss Elizabeth Hearn | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? American | |
| 18. 420.14E904.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH pulmonary congestion. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | severe coronary heart disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | status 5 days post fx. of hip, lt. 4" K. Bone. | | | |
| 19A. DATE OF OPERATION 9/5/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fr. lt. hip | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) at home House | |
| 21D. TIME OF INJURY (APPROX.) 9/3/66 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from Sep. 3 1966 to Sep. 9 1966, that (X) (we) last saw the deceased alive on Sep. 9, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. E. Hsu | | | | 23B. DATE SIGNED Sep. 9 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DR. J E HSU | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 13 Sept 66 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Burgee Funeral Home, 3631 Falls Road | |
| VS 150-REV. 1/1/65 | | N820.0 | | Baltimore, Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

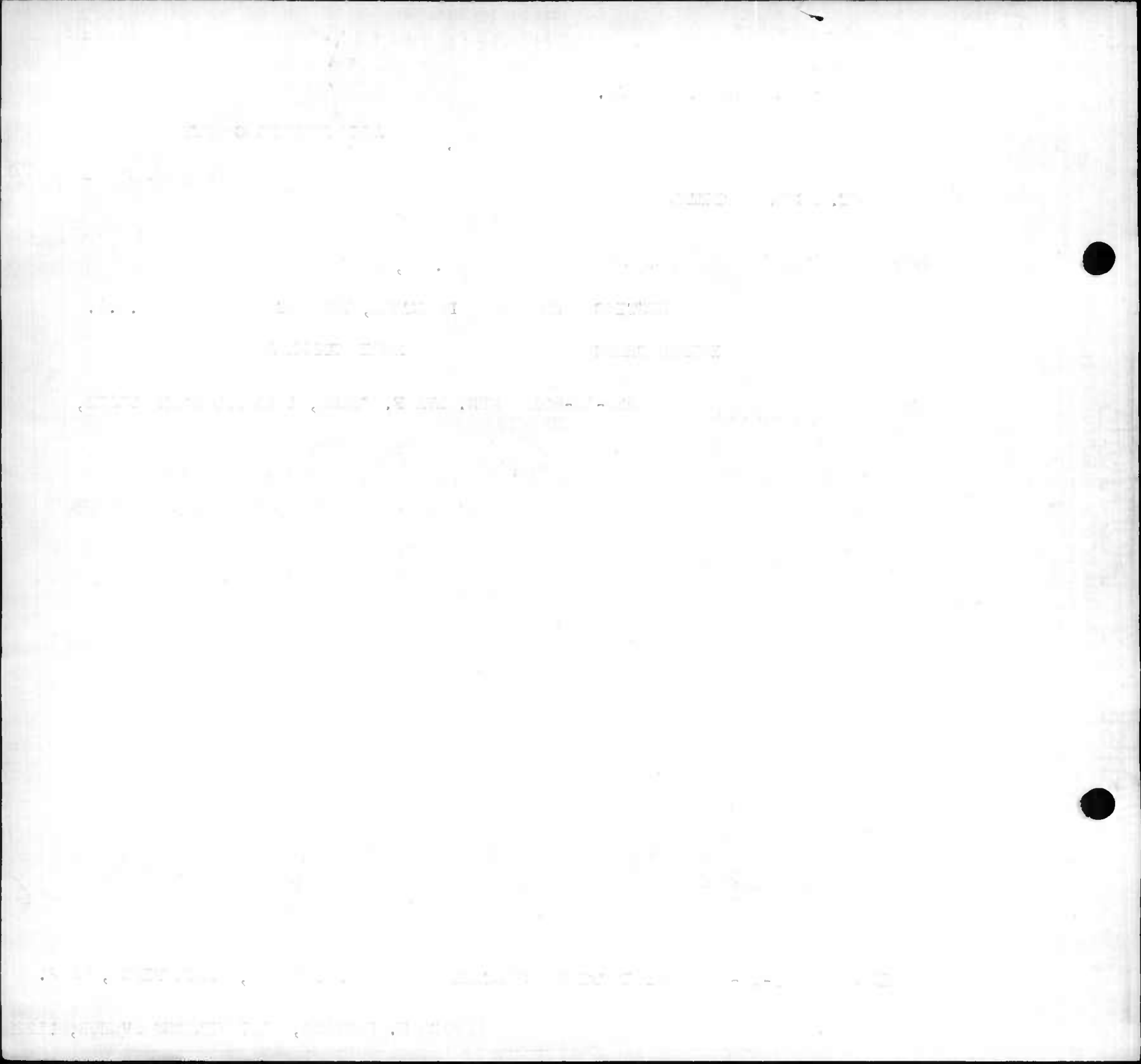
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09248 | |
|--|-----------|--|--------------------------|--|--|
| BIRTH NO. 66 09248 | | STELLA | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anastasia Violet BEDNARCZYK | | 2. DATE AND HOUR OF DEATH SEPT. 11, 1966. 9:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Md. | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 North Charles General Hospital | | 6. STREET ADDRESS (If rural, give location) 502 S. Savage St. | | 7. AGE (In years last birthday) 63 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12-5-02 | 9. AGE (In years last birthday) 63 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME JOSEPH BUTZKO | | 14. MOTHER'S MAIDEN NAME ROSE ALBANOWICZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) C.V.A. due to Cerebral hemorrhage. (B) Hypertension and hypertensive. A.S. Cardiovascular disease. (C) Coronary Arteriosclerosis. | | INTERVAL BETWEEN ONSET AND DEATH one day | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work Not While At Work | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (the hospital) attended the deceased from 1965 19 to Sept 11 1966, that (I) (we) last saw the deceased alive on Sept 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ataollah Golpira M.D. | | 23B. DATE SIGNED Sept 11, 1966 | | | |
| 23C. PHYSICIAN'S NAME (Type) ATAOLLAH GOLPIRA M.D. | | 23D. ADDRESS 1942 Cedar Lane, Balto Md. 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY OR CREMATORY Garden of Faith. | |
| 24D. LOCATION (City, town, or county) Baltimore Md. | | 24E. FUNERAL DIRECTOR Walter Dabrowski 1005 Dunderberg Ave. | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Sisk | | 25C. FUNERAL DIRECTOR Walter Dabrowski 1005 Dunderberg Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09249 | |
|--|-------------------------|--|---|---|---|
| BIRTH NO. 66 09249 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Green, John A. SR. | | | 9/12/66 5:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | | A. STATE Md. B. COUNTY ANNE ARUNDEL COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21226 ORCHARD BEACH | | |
| | | | D. STREET ADDRESS (If rural, give location) 1016 Belvedere Place | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Sept. 28, 1890 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE | 11. BIRTHPLACE (State or foreign country) POULTNEY, VERMONT | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME IOLAND GREEN | | | 14. MOTHER'S MAIDEN NAME ANNIE GREEN JONES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na at unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 026-10-6219 | 17. INFORMANT ADDRESS MRS. EVA F. GREEN, 1016 BELVEDERE PLACE, | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Howard H. Hubbard</i> | | | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-16-66 | | 24C. NAME of CEMETERY or CREMATORY SPRINGFIELD CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) HAMPDEN CO, SPRINGFIELD, MASS. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i> | | 25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21229 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGE

| BIRTH NO. 66 09250 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09250 | | | |
|--|---------|--|------------------|--|----------------------------|--|-----------------------------|--|--|--|--|
| M.E. CASE NO. | | | | | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| Robert Lee Mc Clure | | | | Sept. 11, 1966 | | | | 9: 51 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE SC | | | | B. COUNTY | | | |
| US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | West Columbia | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 1113 Ontario St. | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| M | W | Married (Sep) | 8/29/06 | 60 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| AB seaman | | | | Seafarer | | | | NC | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | USA | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Samuel L. Mc Clure | | | | Daisy Mc Clellan | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| Yes USN 1924-1927 | | | | 244-03-1958 | | | | Mrs. H. C. Nuttall, same as 4d Records- US PHS Hospital, Balto, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Septicemia | | | | Days | | | |
| ANTECEDENT CAUSES | | | | Gama streptococci | | | | Days | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II | | | | Bronchogenic carcinoma | | | | Mos. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| | | | | | | | | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 27 1966 to Sept. 11 1966, that (1) (we) lost saw the deceased alive on Sept. 11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | | | |
| Michael E. Pelczar M.D. | | | | 9/12/66 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| Michael E. Pelczar, SA Surgeon (R) M.D. | | | | US PHS Hospital, Balto, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME of CEMETERY or CREMATORY | | | |
| BURIAL | | | | 9-14-66 | | | | GILFORD MEMORIAL CEMETERY | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | HIGH POINT, NORTH CAROLINA | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | |
| SEP 14 1966 | | | | R. E. E. E. E. | | | | HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29 | | | |

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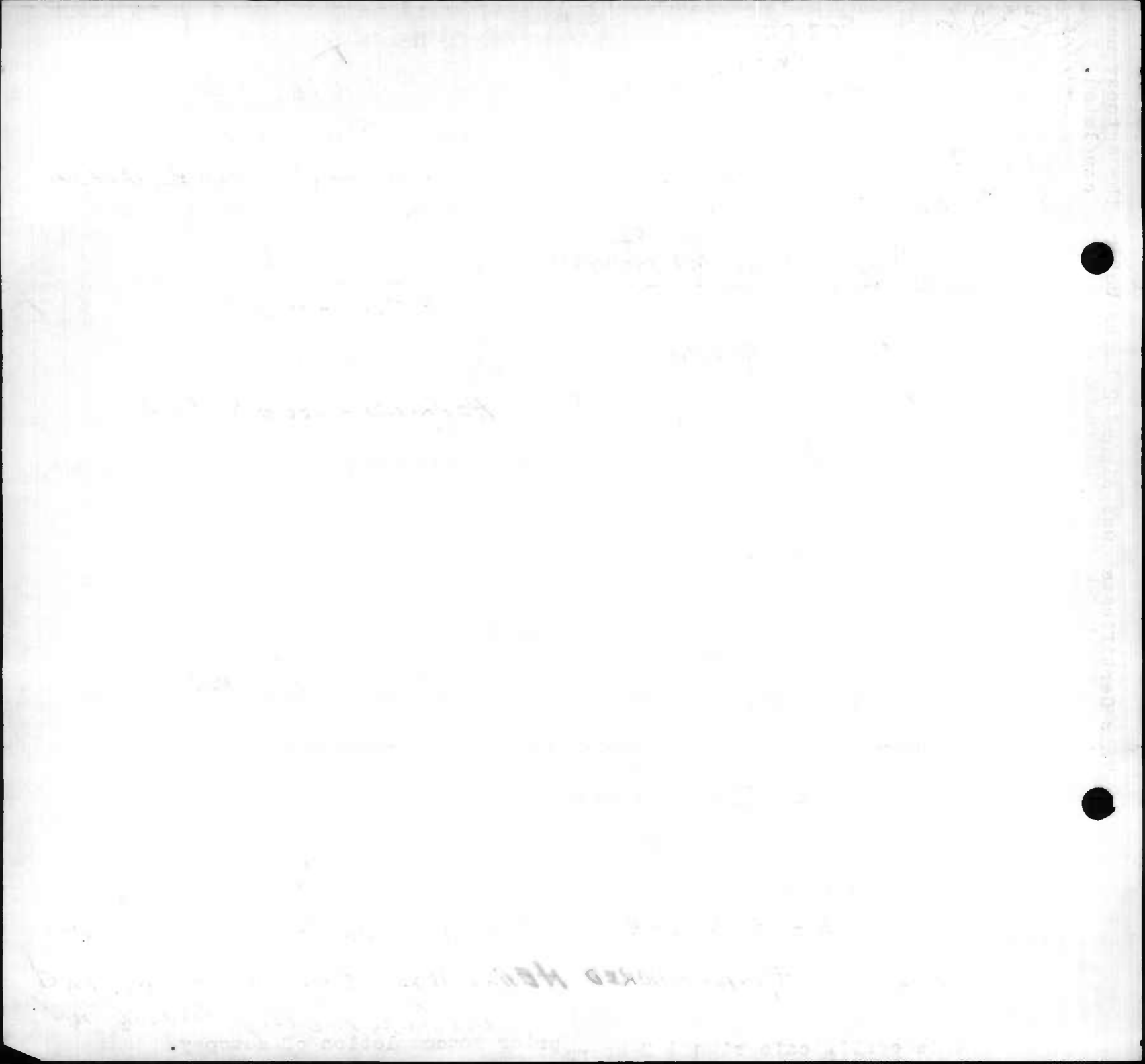
1942

This Certificate was signed 2 hours before the autopsy was completed. **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09251 | |
|---|------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09251 | | M.E. CASE NO. 66 09251 | | | |
| 1. NAME OF DECEASED (Type or Print) SCOTT JAMES A STACHAROWSKI | | | 2. DATE AND HOUR OF DEATH 9-11-66 2:10 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS CHILDREN'S MEDICAL AND SURGICAL CENTER | | | A. STATE MD. B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE DUNDALK 21222 | | |
| | | | D. STREET ADDRESS (If rural, give location) 3494 DUNHAVEN ROAD 5300 | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (specify) NOT MARRIED | 8. DATE OF BIRTH 7-24-60 | 9. AGE (In years last birthday) 6 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) U.S. MARYLAND | |
| 13. FATHER'S NAME J. STACHAROWSKI | | | 14. MOTHER'S MAIDEN NAME BRANDANE WENIGSKI | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 0 | | 16. SOCIAL SECURITY NO. 0 | | 17. INFORMANT ADDRESS HOPKINS = SEE #3 ABOVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| (A) RHABDOMYOSARCOMA | | | 1 1/2 YEARS | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eva McHugh | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> HOUSE Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-11-66 |
| 23C. PHYSICIAN'S NAME (Type) EVA R. MCHUGH | | | 23D. ADDRESS THE Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY SACRED HEART JESUS | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE Co., md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Stanley | | 25C. FUNERAL DIRECTOR William R. Kelly, Deloitte, NY | |

This certificate signed 2 hours prior to completion of autopsy. WBB



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|----------------------------|--|---|---|--|
| 66 19351 66 09252 | | CITY HEALTH DEPARTMENT | | Registered No. 66 09252 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) BABY Fisher | | | 2. DATE AND HOUR OF DEATH 9-10-66 5:05 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28 | | |
| | | | D. STREET ADDRESS (If rural, give location) 2112 Alvin Ave. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED OR NEVER MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9/10/66 | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? 30 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | |
| 13. FATHER'S NAME Charles Fisher | | | 14. MOTHER'S MAIDEN NAME Catherine Brosenne | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Catherine Fisher, 2112 Alvin Ave. Balto. 28 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 770.01 Hydrops fetalis Antecedent causes Rh sensitization | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 10 1966 for 30 min that (I) (we) last saw the deceased alive on Sept 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aleyde A. Melocoton | | | 23B. DATE SIGNED 9-10-66 | | |
| 23C. PHYSICIAN'S NAME (Type) ALEYDE A. MELOCOTON | | | 23D. ADDRESS Bon Secours Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-12-1966 | | 24C. NAME OF CEMETERY OR CREMATORY Good Shepherd | |
| 24D. LOCATION (City, town, or county) (State) Ellicott City, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR F.C. Higginbotham | | 25C. FUNERAL DIRECTOR ADDRESS F.C. Higginbotham, Ellicott City, Md | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|-----------------------------------|--|--|--|---|--|--|--|--|--|
| BIRTH NO. <u>66-19420</u> M.E. CASE NO. <u>66 09253</u> | | | | | CERTIFICATE OF DEATH | | | | | Registered No. <u>66 09253</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) BUCHLEITNER BABY BOY | | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1966 6:50A M. | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK D. STREET ADDRESS (If rural, give location) BOX 540-F MANOR ROAD | | | | | | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEWBORN | | 8. DATE OF BIRTH 9-9-66 | | 9. AGE (In years last birthday) 2 10 | | If Under 1 Yr. Months: Days: 2 10 | | If Under 24 Hrs. Hours: Min. 2 10 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 13. FATHER'S NAME XXXXXXXXXX John Buchleitner | | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXX Janis E. Dodge | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS | | | | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Immataturity DUE TO (A) Immataturity (B) (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION SEP 9 1966 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 9 19 66 to SEPTEMBER 9 19 66 , that (I) (we) lost saw the deceased alive on SEPTEMBER 9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>C. P. Arellano</i> | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-9-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) C. ARELLANO | | | | | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVES | | | | #29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 12 Sept. 66 | | | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park | | | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | | | 25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md. | | | | ADDRESS | | | |

RECEIVED OCT 10 1961

SEPTEMBER 2, 1961

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66 09254

BALTIMORE CITY HEALTH DEPARTMENT

66 09254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Frank J. Wimmer

2. DATE AND HOUR PRONOUNCED DEAD

9-9-66

8:14 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

513 N. Linwood Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 13, 1896

9. AGE (In years last birthday)

69

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Meat Cutter

10B. KIND OF BUSINESS OR INDUSTRY

Wetzelberger's

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Karl Wimmer

14. MOTHER'S MAIDEN NAME

Alberta Shettle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W.1 - Army 220-03-5001

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary Barbernitz Wimmer, wife, above

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-10-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/13/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

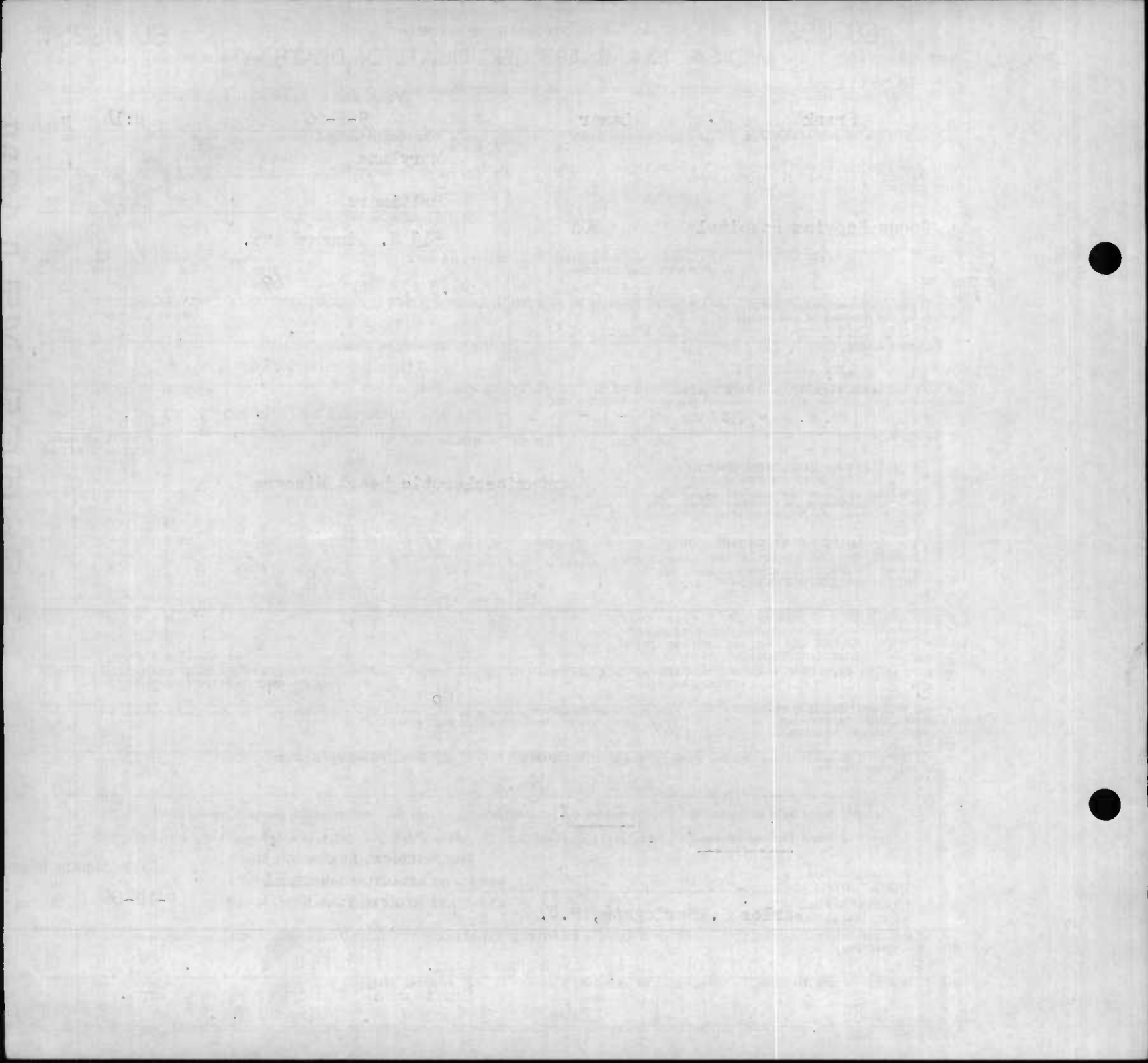
24C. FUNERAL DIRECTOR

ADDRESS

SEP 14 1966

Robert E. Taylor, M.D.

Schimunek Funeral Home, Inc.
2601 E. Madison St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|---|---|---|
| <p style="font-size: 24pt; margin: 0;">66 09255</p> | | <p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="margin: 0; font-size: 18pt;">CERTIFICATE OF DEATH</p> | | <p style="font-size: 24pt; margin: 0;">66 09255</p> | |
| <p>BIRTH NO. 66 09255</p> | | <p>Registered No. 66 09255</p> | | | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) MARION J. LAUGHLIN</p> | | <p>2. DATE AND HOUR OF DEATH September 11, 1966 6:15 a.m.</p> | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 18pt;">House in the Pines (Belair Rd.)</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)</p> <p>A. STATE Md. 21205 B. COUNTY 26-44</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 914 N. Janney St.,</p> | | | |
| <p>5. SEX male</p> | <p>6. RACE white</p> | <p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married</p> | <p>8. DATE OF BIRTH 2/10/1893</p> | <p>9. AGE (In years last birthday) 73</p> | <p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock</p> | | <p>11. BIRTHPLACE (State or foreign country) Baltimore, Md.</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> | | <p>13. FATHER'S NAME Mation Laughlin</p> | | | |
| <p>14. MOTHER'S MAIDEN NAME Katherine Lamars</p> | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. 1</p> | | | |
| <p>16. SOCIAL SECURITY NO. 220-05-8794A</p> | | <p>17. INFORMANT ADDRESS Ida Helmbold Laughlin, wife, above</p> | | | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction</p> | | <p>CAUSE OF DEATH (A) DUE TO Anteroseptal Heart Disease</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH 24 hrs.</p> | |
| <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II</p> | | <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia of Unknown Cause</p> | | <p>Old thrombotic middle cerebral artery</p> | |
| <p>19A. DATE OF OPERATION</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | | |
| <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from June 6, 1966 to September 11, 1966, that (I) (we) last saw the deceased alive on September 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE Albert D. Bradley</p> | | <p>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | | <p>23B. DATE SIGNED 9/13/66</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) Dr. Albert Bradley</p> | | <p>23D. ADDRESS 4900 Belair Road</p> | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 9/15/66</p> | | <p>24C. NAME of CEMETERY or CREMATORY Balto. Nat. Cem.</p> | |
| <p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p> | | <p>25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966</p> | | | |
| <p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane</p> | | | |

241
C. J. H. H. H.

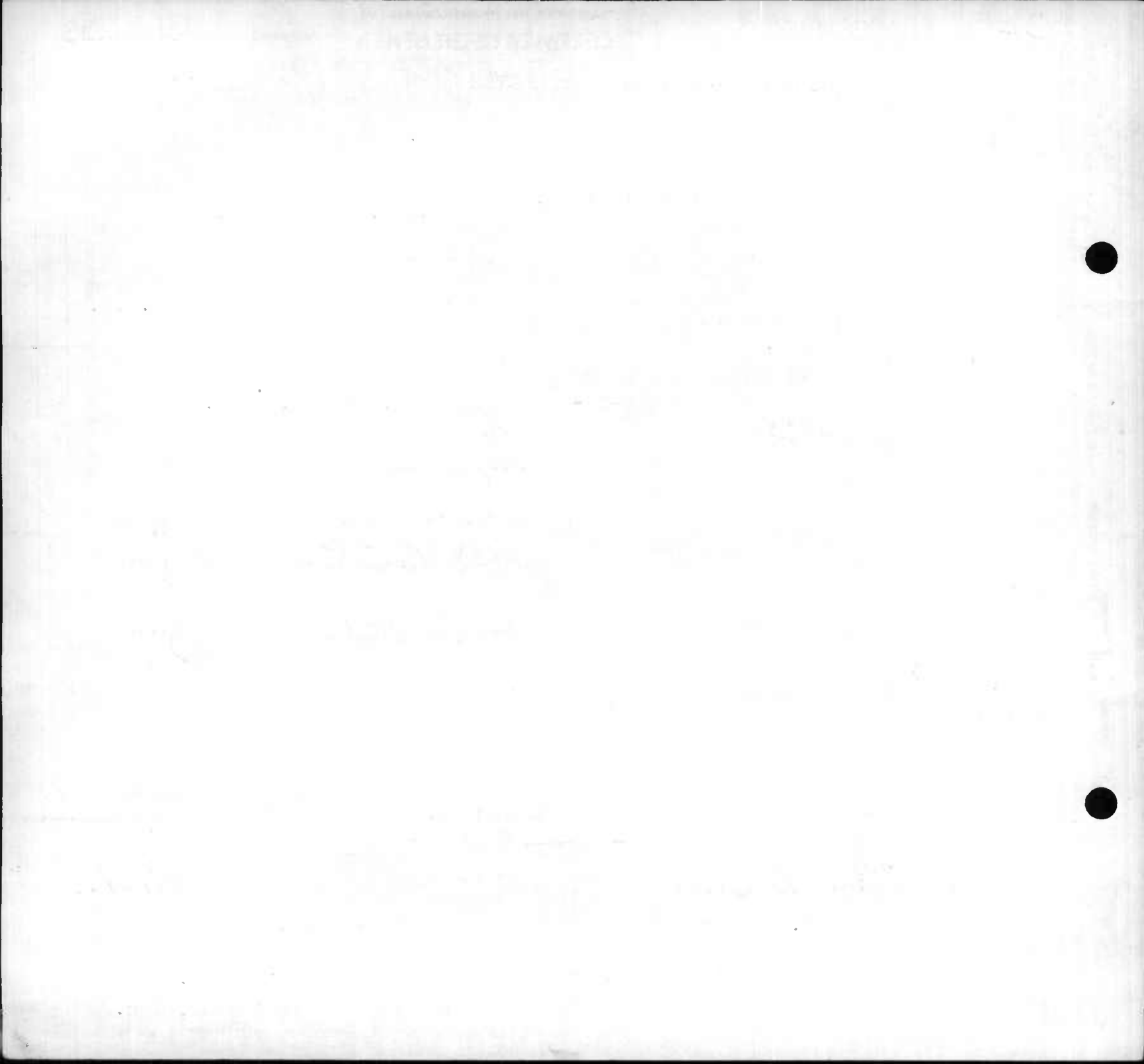
242
C. J. H. H. H.

243
C. J. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|---|--|
| BIRTH NO. 66 09256 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09256 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) ALMA WALTERS or WALTER | | | 2. DATE AND HOUR OF DEATH Sept. 12-66 2:05 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines (Belair Rd.) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 21224 B. COUNTY 26-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 421 N. East Avenue | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 6/21/91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME George M. Herdan | | |
| 14. MOTHER'S MAIDEN NAME Wilhemine Poduschnick | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 214-14-4121A | | |
| 16. SOCIAL SECURITY NO. 214-14-4121A | | | 17. INFORMANT ADDRESS 1524 Fidelity Bldg. Gordon S. Duvall, atty. | | |
| 18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Deaenitis ulcer Thyroid Contractions | | | CAUSE OF DEATH (A) Septicemia (B) Deaenitis ulcer (C) Thyroid Contractions | | |
| INTERVAL BETWEEN ONSET AND DEATH weeks years years | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple Strokes | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 19 63 to Sept. 19 66 , that (I) (we) last saw the deceased alive on July 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B Bradley | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/12/66 |
| 23C. PHYSICIAN'S NAME (Type) Dr. Albert Bradley | | | 23D. ADDRESS 4900 Belair Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



66 09257

BALTIMORE CITY HEALTH DEPARTMENT

66 09257

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN L. JONES

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1966 6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1630 Ashland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1630 Ashland Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4/5/21

9. AGE (In years
last birthday)

43 41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CEPHAS JONES

14. MOTHER'S MAIDEN NAME

CARRIE L. ROSS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

33547833

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ROSSIE JONES 1535 E. MADISON ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Chronic Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/16/66

23C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

(State)

5501 Frederick Ave.

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1966

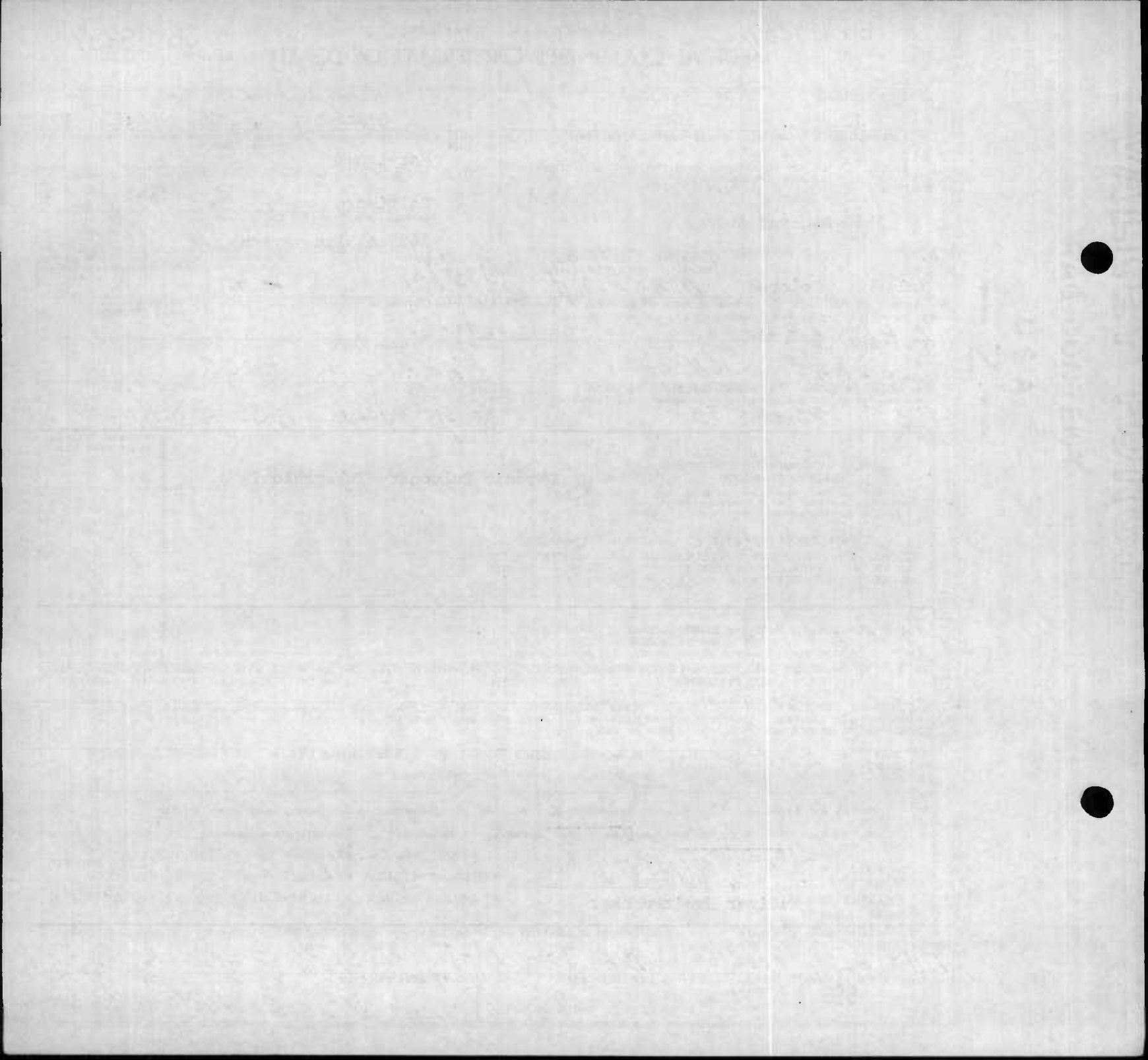
24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Joseph V. Locks 1304 N. Central Ave

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John

BOUKNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1966 7:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1849 Castle Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1849 N. Castle Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

11-2-33

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Holiday Inn

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis Bouknight

14. MOTHER'S MAIDEN NAME

Lucinda Werts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Louis Bouknight 1849 Castle St

18.

E9258-322,0

CAUSE OF DEATH

Asphyxia due to airway compression
during acute ethylismINTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1849 N. Castle Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

9-11-66 3 & 7:00 A

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell asleep with
neck over back chair

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/16/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION (City, town, or county)

A.A. County - Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 14 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Joseph E. Lockyer 1304 N. Central St

ADDRESS

VALLEY-FORGE

AND CONTENT

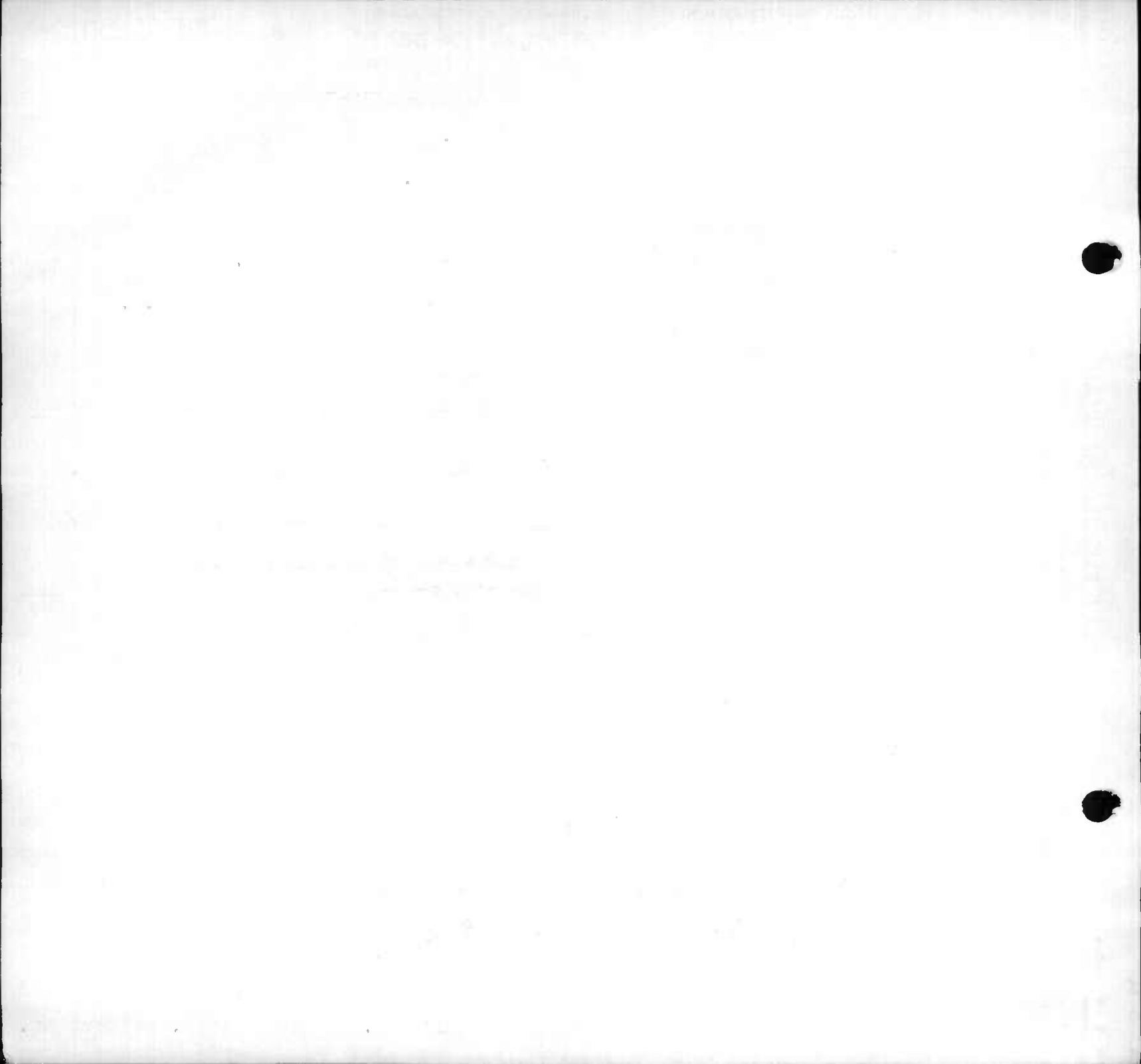
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Valley Forge and its history
and its content

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09259 | |
|--|-------------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09259 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jennie Washington | | 2. DATE AND HOUR OF DEATH 9-10-66 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 13-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 2537 McCulloh Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH 6-5-90 | 9. AGE (In years last birthday) 76 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Arbram Powell | | 14. MOTHER'S MAIDEN NAME Mary Conway | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Lilly Stevenson 2537 McCulloh Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450.0 I CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Divericulitis & Intestinal DUE TO (C) Stress, Degenerative Arterio-sclerosis INTERVAL BETWEEN ONSET AND DEATH 8 days 4 weeks | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-15- 19 66 to 9-10- 19 66 , that (I) (we) last saw the deceased alive on 9-9- 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. Bradshaw Higgins M.D. | | | | 23B. DATE SIGNED 9-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) I. Bradshaw Higgins M.D. | | | | 23D. ADDRESS 2243 Madison Ave. Bldg. 17th | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Arbutus, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS George G. Kelson 1348 N. Calhoun St. | | | |

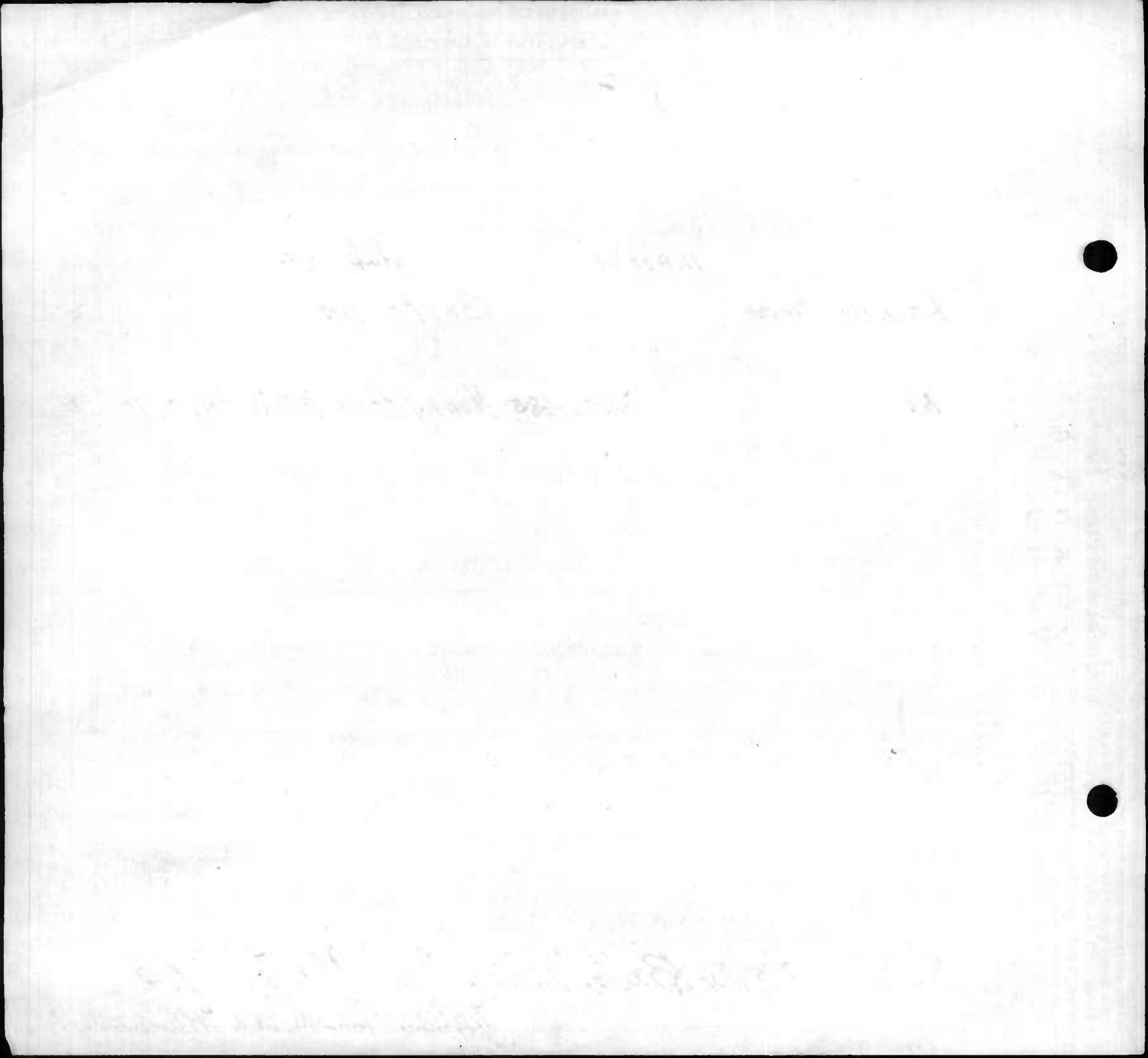


Released by Mr. Gregory. M.E.O. 9/11/66
F. 6301

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09260 | |
|--|-----------|--|--|---|--|
| BIRTH NO. 66 09260 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | FORD, Eleanor | | 9/11/66 7:56 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| | | | | A. STATE Md B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| University of Maryland Hospital | | | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 903 W Fayette St | | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/23/1926 | 9. AGE (in years last birthday) 40 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker | | | 11. BIRTHPLACE (State or foreign country) Balto Md | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Maceo Thompson | | | 14. MOTHER'S MAIDEN NAME Hattie DeShields | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 26-20-680 | | 17. INFORMANT ADDRESS Henry Ford 903 W. Fayette St |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | | (A) DUE TO | | Ca of Cervix 2 year. |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11 19 66 to 9/11 19 66, that (I) (we) lost saw the deceased alive on 9/11/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Baunermann | | | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) H. BAUNERMANN | | | | 23D. ADDRESS M.D. University of Md. Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY or CREMATORY Balto. National Cem. | |
| 24D. LOCATION (City, town, or county) Balto. | | 24E. (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Williams Funeral Home 919 N. Howard St | |



FUNERAL DIRECTOR: IMPORTANT

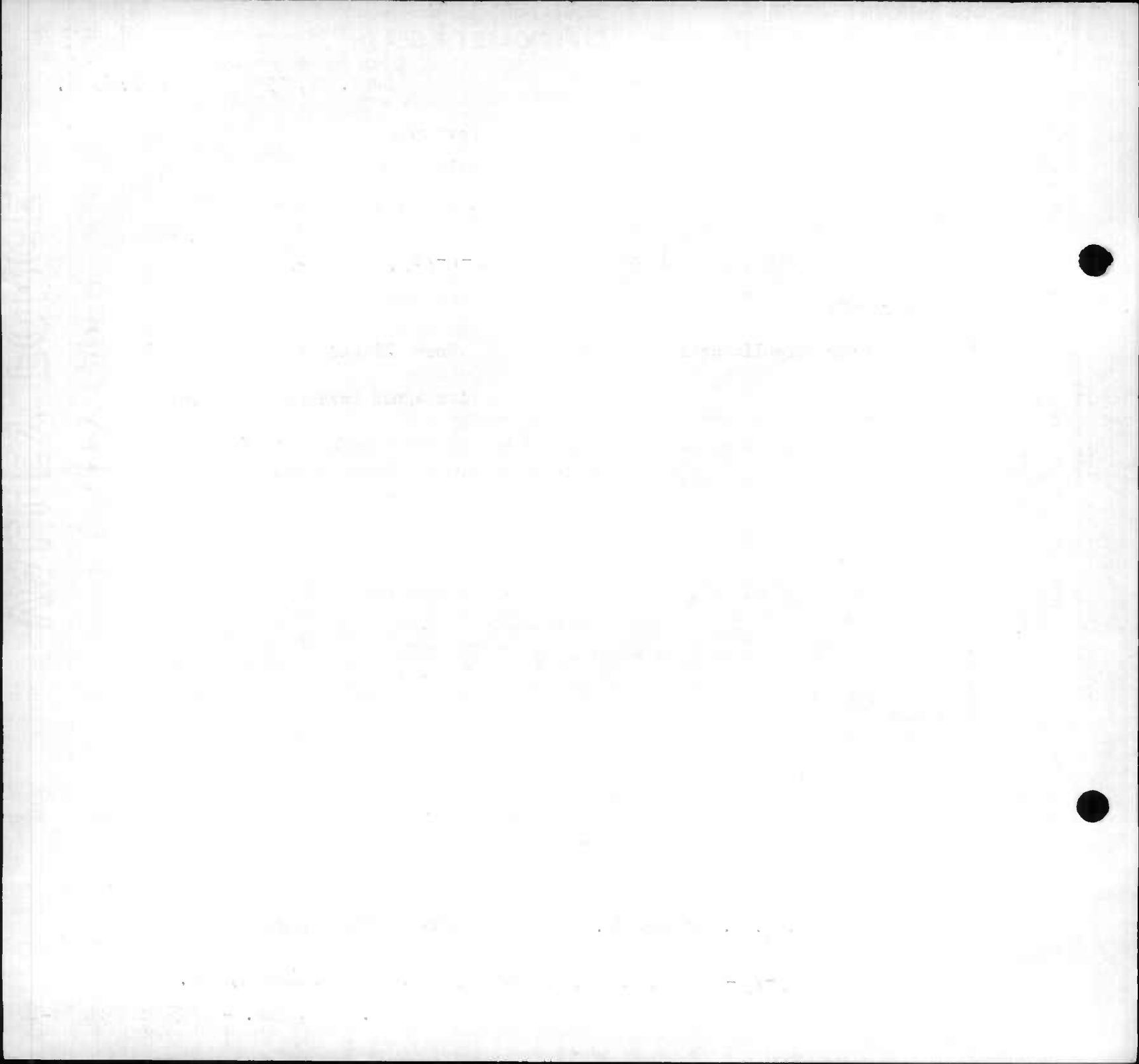
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 66 09261 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09261 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Brewer, Mrs. Nellie D.</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 13, 1966</u> <u>3⁰⁵</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>28-02</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital.</u> | | D. STREET ADDRESS (If rural, give location) <u>3003 Ferndale Ave.</u> | | 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <u>8/14/92</u> 9. AGE (In years last birthday) <u>74</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Abraham Dayton</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Annie Whitehair</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>236-16-2614</u> | |
| 17. INFORMANT <u>Nellie D. Brewer</u> | | ADDRESS <u>3003 Ferndale Ave</u> | | 18. CAUSE OF DEATH <u>Arteriosclerosis - Anticoagulant Heart</u> | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis - Anticoagulant Heart</u> | | 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Disease - Dehydration</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 9, 1966</u> to <u>September 13, 1966</u> . that (I) (we) last saw the deceased alive on <u>September 13, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>SAM L. BARTON</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>SAM L. BARTON</u> | | M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-16-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>DAYTON Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>McCoole, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>ELLISWORTH ARMACOST</u> | | ADDRESS <u>4600 Liberty Hts</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

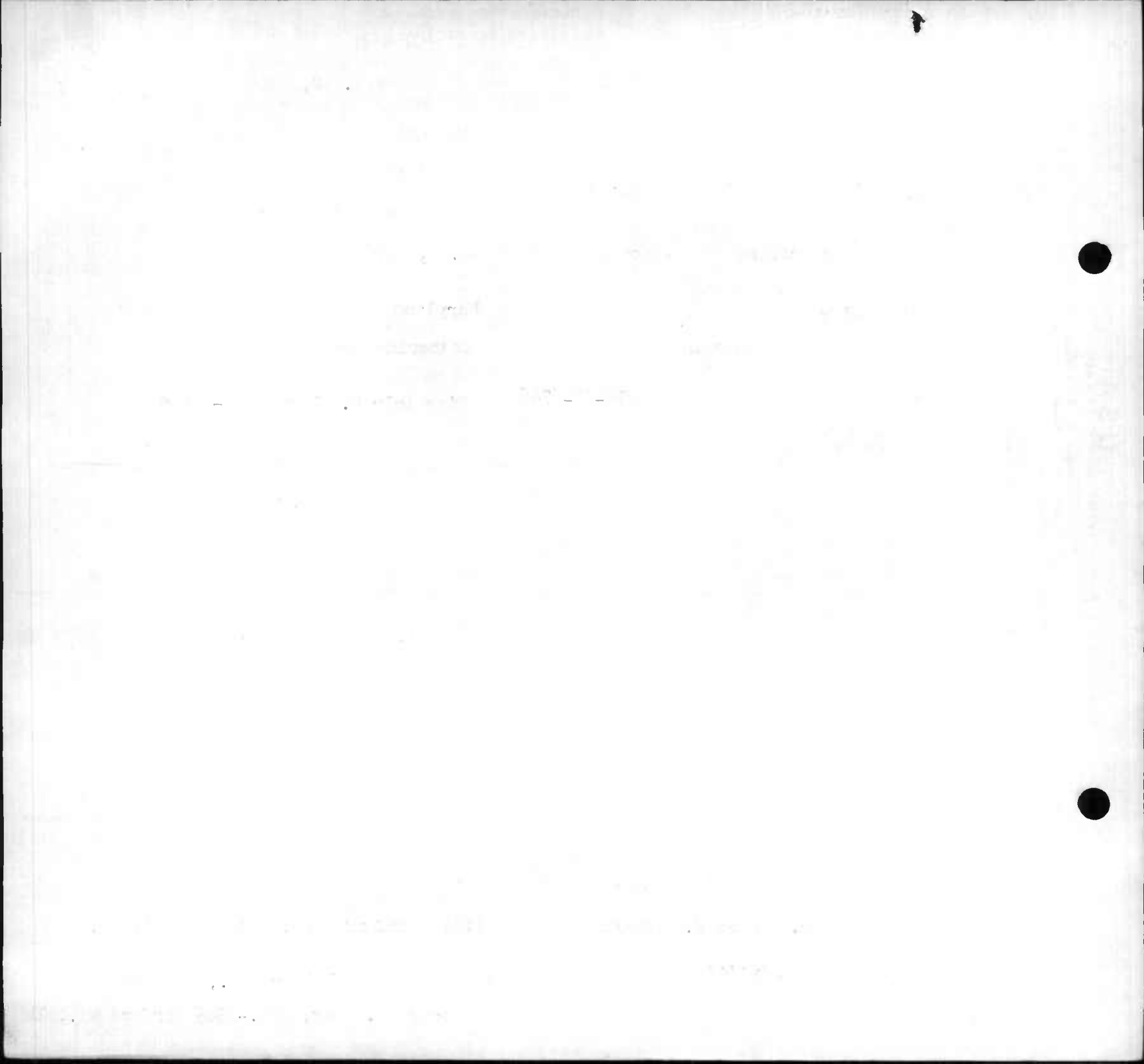
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 09262</u> | |
|--|-----------------------------|--|--|--|---|--|--|
| BIRTH NO. <u>66 09262</u> | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>ELIZABETH PAZERAS</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 14, 1966</u> <u>1:00 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>5009 Catalpha Road</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5009 Catalpha Road</u> | | | |
| 5. SEX <u>female</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u> | 8. DATE OF BIRTH <u>6-1-1879</u> | 9. AGE (In years last birthday) <u>87</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Lithuania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Peter Grebliauckas</u> | | | 14. MOTHER'S MAIDEN NAME <u>Rose Zilanskas</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Miss Agnes Pazeras 5009 Catalpha Road</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>422141260X</u> <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | CAUSE OF DEATH <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO | | | | |
| | | | (B) DUE TO | | | | |
| | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | <u>Diabetes Mellitus</u> | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> 19 <u>66</u> to <u>Sept 14</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>George Sawyer Jr.</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/14/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. G. J. Sawyer, Jr.</u> | | | 23D. ADDRESS <u>4808 Harford Road, Baltimore</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | 24B. DATE <u>9-17-66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. - 5305 Harford Rd-14</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09263 | |
|--|-----------------------------|---|---|--|---|
| BIRTH NO. 66 09263 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELIZABETH OBERENDER | | 2. DATE AND HOUR OF DEATH Sept. 12, 1966 7:15 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-34 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 5418 Rimmell Avenue | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 5418 Rimmell Avenue | | | |
| 5. SEX female | 6. RACE caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH Feb. 6, 1876 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Henry Scharoun | | 14. MOTHER'S MAIDEN NAME Catherine Kramer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-09-6746 | | 17. INFORMANT Miss Lulu R. Oberender - Same | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident due to Generalized Arteriosclerosis | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 days 20 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Aortic Aneurysm (abdominal) | | | | 1 year | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Sept 1966 , that (I) (we) last saw the deceased alive on 12 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas J. Brennan | | | | 23B. DATE SIGNED 13 Sept 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Thomas J. Brennan | | 23D. ADDRESS 5217 Harford Road, Baltimore 14, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9/16/66 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-5305 Harford Rd., 14 | |



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B-120

66 09264

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09264

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ANNA BAVIS | | | | 2. DATE AND HOUR PRONOUNCED DEAD September 12, 1966 4:38 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01 D. STREET ADDRESS (If rural, give location) 1214 Wilcox | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH March 29, 1912 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | 13. FATHER'S NAME George W. R. Brooks | | |
| 14. MOTHER'S MAIDEN NAME Margaret A Constant | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-34-1206 | | | 17. INFORMANT ADDRESS James J Bavis 1213 Wilcox St. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO - INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/13/66 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/16/66 | | 23C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 23D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 24A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | | |
| 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc 5305 Harford Rd | | | |

U.S.A.

March 29, 1912

My dear Sir,

I have the pleasure to

acknowledge the receipt of your letter of the 21st inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Yours faithfully,

W. H. H. H.

John H. H. H.

John H. H. H.

John H. H. H.

John H. H. H. 2200 Bedford St.

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S-636

66 09265 BALTIMORE CITY HEALTH DEPARTMENT 66 09265

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) ELMER C SHRADER Sr | | 2. DATE AND HOUR PRONOUNCED DEAD September 12, 1966 8:34 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-02 D. STREET ADDRESS (If rural, give location) 4522 Weitzel Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Dec. 11, 1910 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore City | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Elmer R Shrader | | 14. MOTHER'S MAIDEN NAME Sarah A Baker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-09-3558 | 17. INFORMANT Mrs Josephine C Shrader |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 3 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/16/66 | 23C. NAME of CEMETERY or CREMATORY Baltimore |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | 24C. FUNERAL DIRECTOR Leonard J Ruck Inc 5305 Harford Rd |
| 23D. LOCATION (City, town, or county) (State) Baltimore Maryland | | 24D. ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09266 | |
|--|---------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 09266 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Elizabeth Ruberry</i> | | 2. DATE AND HOUR OF DEATH <i>9-13-66</i> <i>2 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>2215 Boyer ST</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>1-2 1900</i> | 9. AGE (In years last birthday) <i>66</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MARYLAND</i> | |
| 13. FATHER'S NAME <i>Michael STERN</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>BERT RUBERRY 3202 WOODRING AVE</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>416X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) <i>ACUTE RENAL FAILURE</i> DUE TO | | <i>3 DAYS</i> | |
| | | (B) <i>CONGESTIVE HEART FAILURE</i> DUE TO | | <i>6 MONS</i> | |
| | | (C) <i>RHEUMATIC HEART DISEASE</i> | | <i>35 yrs</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>9/9/66</i> 19 to <i>9/13</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/13</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>FH Cost MD</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/13/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>FH Cost</i> | | 23D. ADDRESS M.D. <i>MERCY HOSPITAL BALT. MD</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/16/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL CEM</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>FREDERICK RD MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>G. D. B. E. For...</i> | | 25C. FUNERAL DIRECTOR <i>DIPPEL BROS INC 1800 E LOMBARD ST</i> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09267 | |
|---|--|--|--|--|--|
| BIRTH NO. 66 09267 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN HOWARD BACHMANN SR | | 2. DATE AND HOUR OF DEATH 9-12-66 5:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 37 MERCY HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | 5. AGE (In years lost birthday) 60 | |
| 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH AUG 20, 1906 | |
| 9. SEX M | | 10. KIND OF BUSINESS OR INDUSTRY MAX. WALLER CO. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ALBERT J. BACHMANN | |
| 14. MOTHER'S MAIDEN NAME FRANCES WOLFE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-01-9465 | |
| 17. INFORMANT ETHEL M. BACHMANN | | 18. ADDRESS 3612 WHITE AVE | | 19. CAUSE OF DEATH (A) Ruptured abdominal aneurysm (B) ASCUD (C) _____ | |
| 20. INTERVAL BETWEEN ONSET AND DEATH 3 hrs. | | 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCUD | | 22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 24. DATE OF OPERATION 2 | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 31. HOW DID INJURY OCCUR? | |
| 32. I certify that (I) (this hospital) attended the deceased from 9/12 19 66 to 9/12 19 66 , that (I) (we) last saw the deceased alive on 9/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 33. SIGNATURE E. Lee Robbins | | 34. DATE SIGNED 9/12/66 | |
| 35. PHYSICIAN'S NAME (Type) E. LEE ROBBINS | | 36. ADDRESS MERCY HOSPITAL | | 37. DATE 9/15/66 | |
| 38. NAME OF CEMETERY or CREMATORY PARKWOOD CEM | | 39. LOCATION (City, town, or county) TAYLOR AVE BALTO. MD | | 40. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | |
| 41. NAME OF REGISTRAR R. P. A. E. Johnson | | 42. FUNERAL DIRECTOR DIPPEL BROS INC | | 43. ADDRESS 710 BELAIR RD (G) | |

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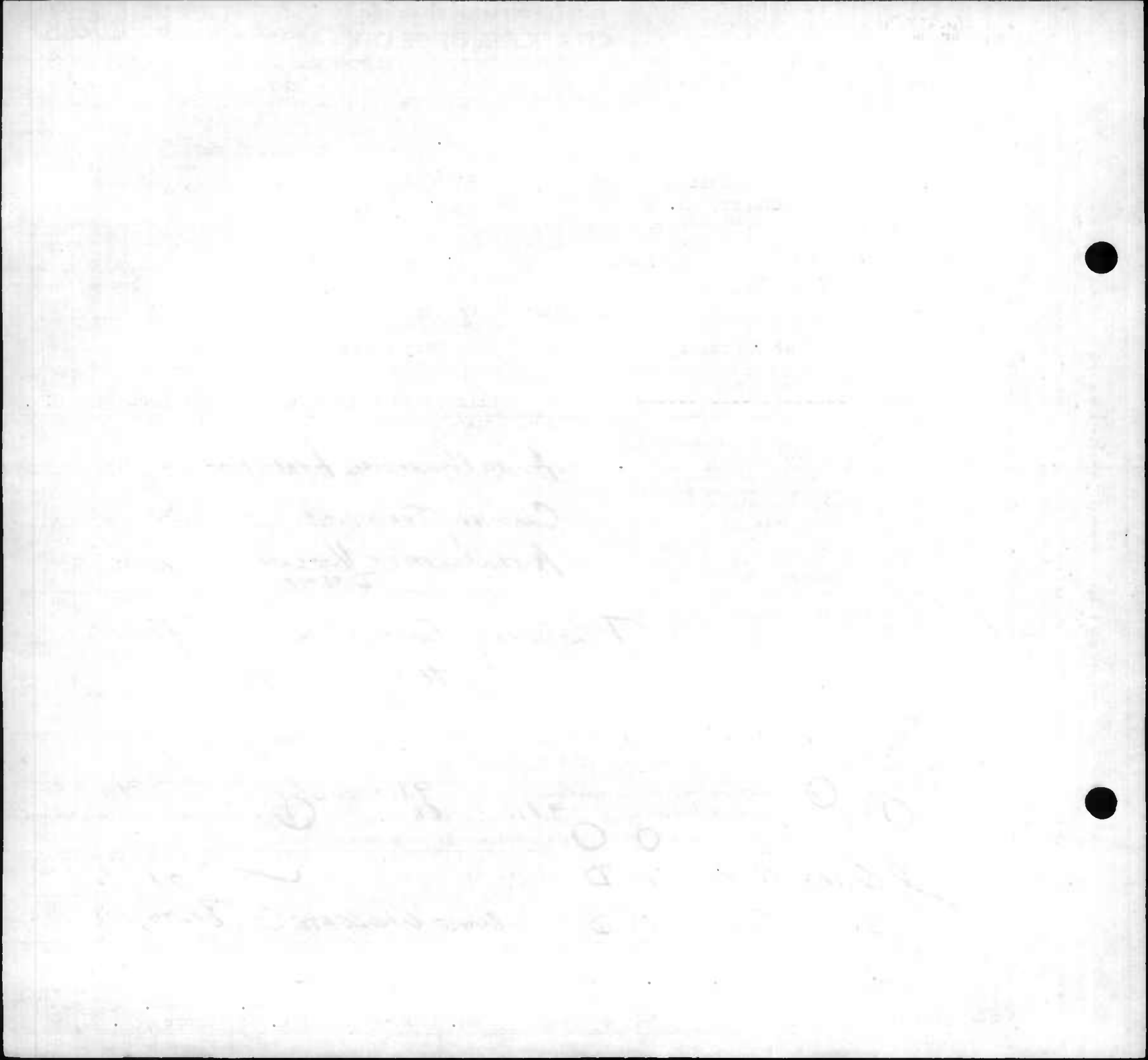
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09268</u> | |
|---|-----------------------|--|--|--|--|
| BIRTH NO. <u>66 09268</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>THOMAS J. GREENE</u> | | | 2. DATE AND HOUR OF DEATH <u>9/11/66</u> <u>8:15</u> <u>A</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37</u> <u>Mercy Hospital</u> <u>Baltimore, Md.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4205 Main Ave</u> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Cau</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>7/13/79</u> | 9. AGE (In years last birthday) <u>87</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea Captain</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Canada</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Joseph Greene</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Grace</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>-----</u> | | | 17. INFORMANT ADDRESS <u>McLaughlin & Sons Funeral Home Brooklyn, N.Y.</u> | | |
| 18. <u>420.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (B) <u>CORONARY THROMBOSIS</u> DUE TO (C) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>24 hr</u> <u>YEARS</u> |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PULMONARY EMPHYSEMA</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 22. I certify that (I) (this hospital) attended the deceased from <u>9/11/66</u> 19 <u>66</u> to <u>9/11/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/11/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE <u>S. Bruce Gerber, M.D.</u> | | | 23B. DATE SIGNED <u>9/11/66</u> | | 23C. PHYSICIAN'S NAME (Type) <u>S. BRUCE GERBER, M.D.</u> |
| 23D. ADDRESS <u>8045 WOODGATE CT., BALTO, MD. 21207</u> | | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | |
| 24B. DATE <u>9/16/66</u> | | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Johns</u> | | |
| 24D. LOCATION (City, town, or county) (State) <u>Queens, New York</u> | | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1966</u> | | |
| 25B. NAME OF REGISTRAR <u>Wm. Cook Brooks Inc.</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>1217 St. Paul St. Baltimore, Md. 21202</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------|--|--|--|---|---------------------------------|--|--|--|
| 66 09269 | | | | | 66 09269 | | | | |
| BIRTH NO. | | | | | REGISTERED NO. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| JOHN P. DEL GIUDICE | | | | | September 13, 1966 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5115 Baltimore National Pike | | | | | A. STATE Maryland | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City | | | | |
| D. STREET ADDRESS (If rural, give location) 5115 Baltimore National Pike | | | | | B. COUNTY | | | | |
| | | | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | | |
| Male | White | Married | | | Nov. 23, 1885 | 80 Years | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 11. BIRTHPLACE (State or foreign country) | | | | |
| (Retired) Tailor | | | | | Italy | | | | |
| 13. FATHER'S NAME | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| Gennard Del Giudice | | | | | U.S.A. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | | | | 219-05-5611 | | 1329 Brook Road Del Langdon Baltimore 28, Maryland | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | | |
| | | | | | (A) acute coronary thrombosis | | | | |
| | | | | | (B) (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | 12 hrs. | | | | |
| 19A. DATE OF OPERATION | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | 21E. INJURY OCCURRED | | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1962 to 1966, that (I) (we) last saw the deceased alive on 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | 23B. DATE SIGNED | | | | |
| HARRY S. GIMBEL | | | | | 9-14-66 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| HARRY S. GIMBEL | | | | | 4605 EDMONDSON AVE - Balt 29/14 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | |
| Burial | | | | | 9/16/1966 | | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | | 24D. LOCATION (County) (City, town, or county) (State) | | | | |
| Moreland | | | | | Baltimore, Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | |
| | | | | | Wm. Cook-Brooks, 1217 St. Paul St. Baltimore, Maryland 2 | | | | |
| 25C. FUNERAL DIRECTOR ADDRESS | | | | | | | | | |

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2000-01-01 to 2000-12-31

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2000-01-01 to 2000-12-31

2000-01-01 to 2000-12-31

2000-01-01 to 2000-12-31

2000-01-01 to 2000-12-31

2000-01-01 to 2000-12-31

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|--|------------------------------------|------------------------------|
| 66 09270 | | 66 09270 | | 66 09270 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| DAYS, ARTHUR | | | 9/11/66 8:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| 3800 COTTAGE AVE | | | A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | MARYLAND, BALTIMORE | | |
| SINAI HOSPITAL OF BALTIMORE | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) | | | 3800 COTTAGE 15-12 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | NEGRO | MARRIED | 4-20-08 | 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Truck Driver | | | 7. G. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Jerry Peoples | | | Mollie Davis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| | | | 17. INFORMANT ADDRESS | | |
| | | | Sadie Davis 3800 Cottage Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 442X I | | | (A) CARDIAC ARREST | | |
| ANTECEDENT CAUSES | | | (B) HCUHD | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) RENAL ARTERY STENOSIS | | |
| II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 9/11/66 | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 0 | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| David L. Spott | | | 9/11/66 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| D. A. SPOTT | | | SINAI HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/17/66 | | Mt. Auburn Cem | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Baltimore, Maryland | | SEP 14 1966 | | Robert E. Farley, M.D. | |
| 24G. FUNERAL DIRECTOR ADDRESS | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR ADDRESS | |
| William C. March 928 E. North Ave | | | | | |



66 09271

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09271

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE BELLE JONES

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1966 2:05 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1227 N. Gilmore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1227 N. Gilmore Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

July 3, 1928

9. AGE (In years
last birthday)

38

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Stewart Hill

14. MOTHER'S MAIDEN NAME

Mary Page Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-56-3214

17. INFORMANT

ADDRESS

Willieann Curtis 1227 N. Gilmore St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
9/8/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/12/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel City, Md.

24A. DATE RECEIVED BY HEALTH DEPT.

SEP 14 1966

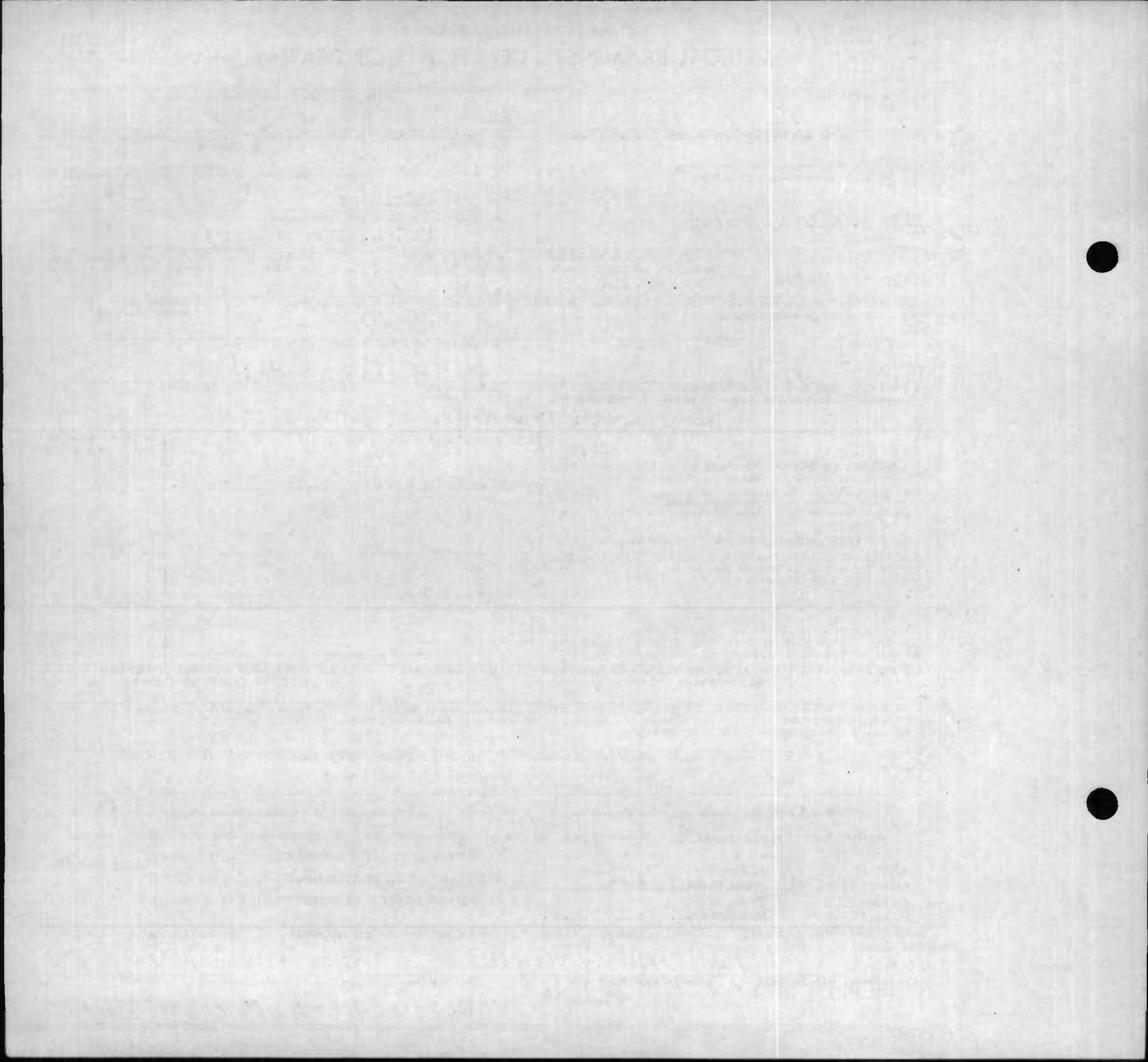
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

William C. March 928 E. North Ave



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09272 | |
|---|---|--|---|---|---|
| BIRTH NO. 66 09272 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Leila Irby | | 2. DATE AND HOUR OF DEATH September 12, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3104 Windsor Ave | | A. STATE Maryland B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 15-47 3104 Windsor Ave | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Sept 8, 1894 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Laurens, South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Samuel Mills | | | |
| 14. MOTHER'S MAIDEN NAME Florence Crout | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 244-50-6780 | | 17. INFORMANT ADDRESS Mrs. Mozell Mitchell 3104 Windsor Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Coronary Occlusion DUE TO (B) Hypertensive Cardio Vascular Dis. Unknown DUE TO (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH Day | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-12-1966 to 9-12-1966 , that (I) (we) lost saw the deceased alive on 9-12-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard H. Hunt | | | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) Richard H. Hunt | | | | 23D. ADDRESS 1607 W. Mulberry St. Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY or CREMATORY Rocky Spring Bapt Ch Cem | |
| 24D. LOCATION (City, town, or county) (State) Laurens, South Carolina | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Robert E. Fadden | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. NORTH AVE | | | |

SEP 14 1966

George C. Brown
1877

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09273 | |
|---|---------------------|---|------------------------------------|--|--|
| BIRTH NO. 66 09273 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Margaret Skinner | | 2. DATE AND HOUR OF DEATH September 12-1966 10:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital | | A. STATE M. Maryland B. COUNTY B. Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6 | | | |
| 48 | | D. STREET ADDRESS (If rural, give location) 1103 Rosedale Ave. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-17-13 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Mazel | | 14. MOTHER'S MAIDEN NAME Catherine Kottwalt | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ? None | | 17. INFORMANT Robt. J. Skinner (Husband) | |
| | | | | ADDRESS Same | |
| 18. 330X I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Subarachnoid Hemorrhage | | | 34 hrs |
| ANTECEDENT CAUSES | | (B) Ruptured Atherosclerotic aneurysm | | | 34 hrs |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertension, severe | | | 30 yrs. |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Sept. 11</u> 19 <u>66</u> to <u>Sept. 12</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Sept. 12</u> 19 <u>66</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Michael Gould | | | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-15-66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR'S ADDRESS Philip E. [Signature] 1211 [Address] | |

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Memorial General Hospital

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George W. Hall

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Memorial General Hospital

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|--|------------------|---|-----------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | 66 09274 | |
| BIRTH NO. 66-09274 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | |
| M.E. CASE NO. 66-12721 | | | |
| 1. NAME OF DECEASED (Type or Print) Patricia L. POLLING (POLING) | | 2. DATE AND HOUR PRONOUNCED DEAD September 11, 1966 7:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33/99 John Hopkins Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 1015 Quantral Way | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 6/16/66 |
| 9. AGE (In years last birthday) 11 weeks 3 | | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Balto Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Robert C. Poling | | 14. MOTHER'S MAIDEN NAME Barbara Hamilton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Parents - same as above | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS WITH focal acute bronchopneumonia (SDII) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 11, 1966 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 9/14/66 | |
| 23C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE | | 23D. LOCATION (City, town, or county) (State) BALTO. MD | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 24B. NAME OF REGISTRAR Robert E. Fairbank | |
| 24C. FUNERAL DIRECTOR Counelly F.H. | | 24D. ADDRESS 300 Mace | |

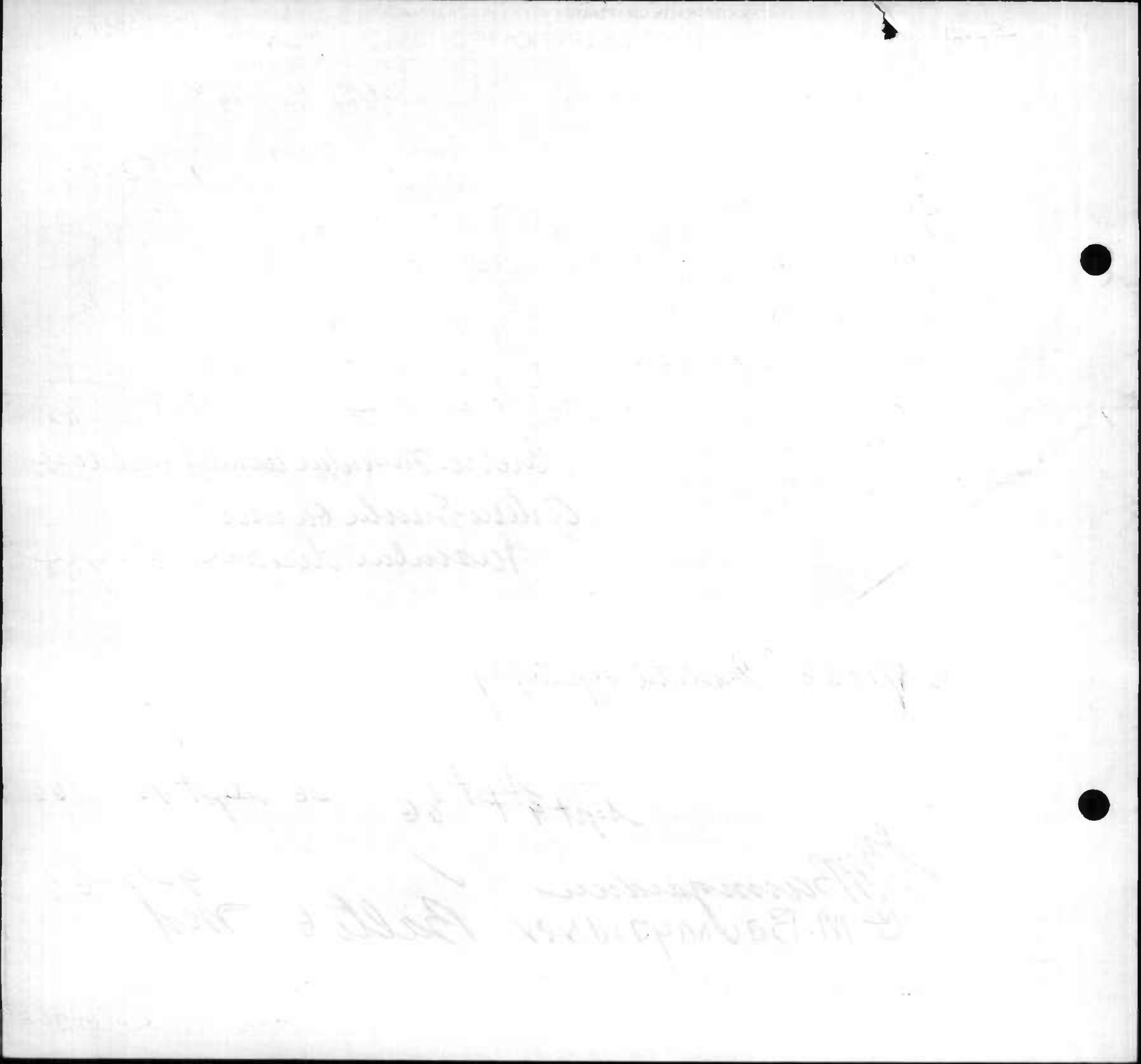
WALLLEY POLICIS

WALLLEY POLICIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

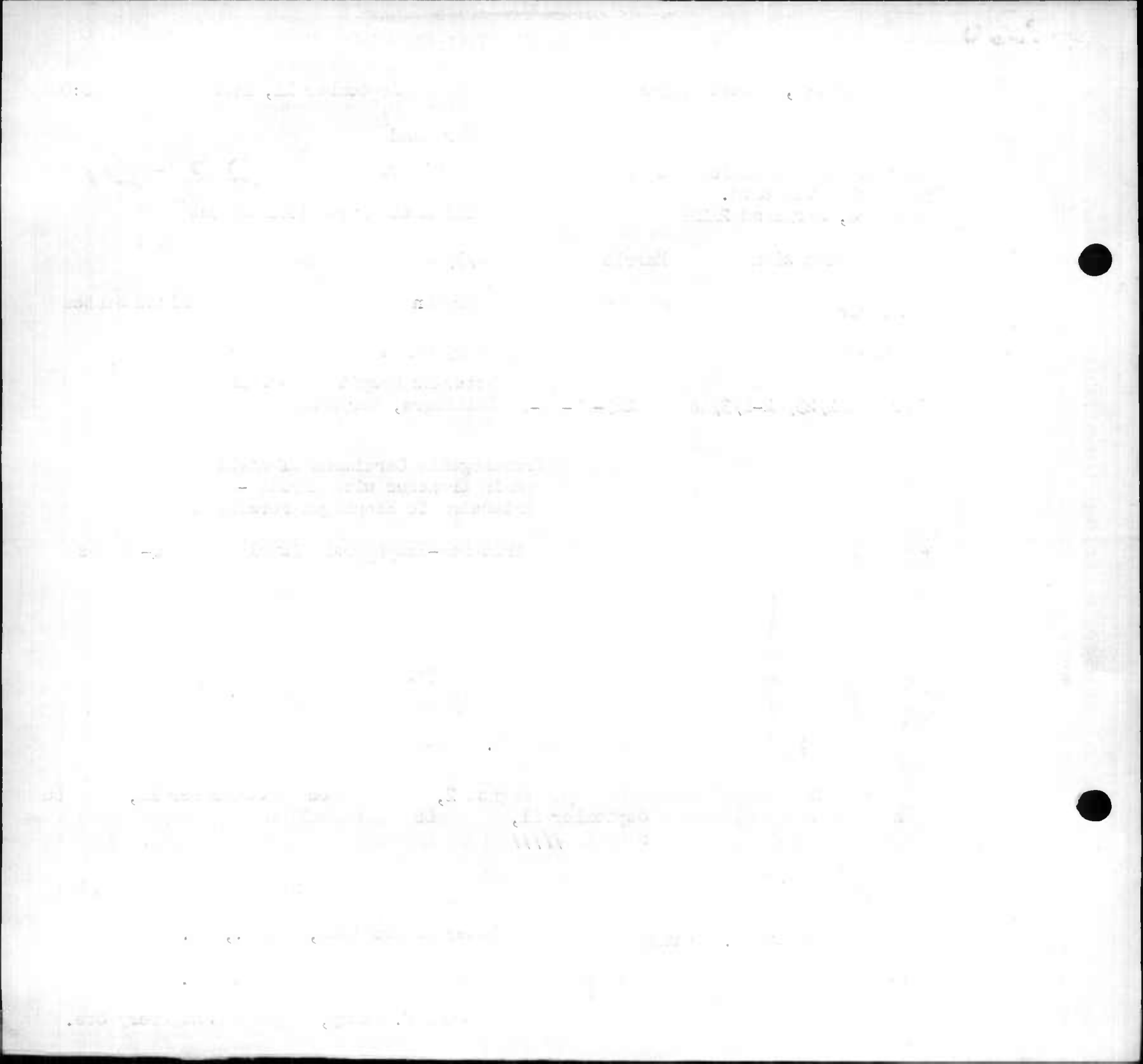
| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 66 09275 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09275 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM DENKER</u> | | | SEPT. 10, 1966 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 GOULD CONL. HOME</u> | | | A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>ESSEX</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>366 TOWNSEND RD</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>DEC. 6, 1883</u> | 9. AGE (In years last birthday) <u>82</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACK SMITH</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>BALL CHEM. CO.</u> | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>HERMAN DENKER</u> | | | 14. MOTHER'S MAIDEN NAME <u>ANNA GERHARDT</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>212-05-8407</u> | | 17. INFORMANT <u>EDNA DENKER</u> ADDRESS <u>366 TOWNSEND RD</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>422.11 I Cerebro-Vascular accident Sudden</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio-Sclerotic Cardio</u> | | | (B) DUE TO <u>Vascular disease 2 yrs</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>8/1/1966</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Prostatic Hypertrophy</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1966</u> to <u>Sept 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 9, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>G. M. Baumgardner</u> M.D. | | | | 23B. DATE SIGNED <u>9-12-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u> M.D. | | | | 23D. ADDRESS <u>BALTO 6 MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/14/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR <u>CONNELLY SONS</u> ADDRESS <u>300 MACE</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|----------------------------|---|--|
| BIRTH NO. 66 09276 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09276 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Ritter, Robert Andrew | | 2. DATE AND HOUR OF DEATH September 11, 1966 6:00A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 22-01 D. STREET ADDRESS (If rural, give location) 115 East Church Hill Street | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/3/16 | 9. AGE (In years lost birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? United States | | 13. FATHER'S NAME Roy Ritter | | 14. MOTHER'S MAIDEN NAME Mary Henley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/23/42-1/3/46 | | 16. SOCIAL SECURITY NO. 213-07-04-15 | | 17. INFORMANT Veterans Hospital Records Baltimore, Maryland ADDRESS | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC CARCINOMA OF RIGHT MAIN BRONCHUS WITH DIRECT - EXTENSION TO ESOPHAGUS FORMING A TRACHAEO-ESOPHAGEAL FISTULA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 6-8 Mos | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from August 2, 1966 to September 11, 1966, that (X) (we) last saw the deceased alive on September 11, 1966 and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert K. Brawley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) Robert K. Brawley | | 23D. ADDRESS Veterans Hospital, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | | 24C. NAME of CEMETERY or CREMATORY Lake View Cemetery | |
| 24D. LOCATION Sykesville, Md. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John F. Denny, Light & Montgomery Sts. | |
| ADDRESS | | | | | |



66 09277

BALTIMORE CITY HEALTH DEPARTMENT

66 09277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WHITNEY

LEE, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1966

7:10

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1500 N. Broadway

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1500 N. Broadway

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Oct. 2, 1935

9. AGE (in years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Whitney Lee Sr.

14. MOTHER'S MAIDEN NAME

Nannie Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-30-7337

17. INFORMANT

ADDRESS

Mrs. Nannie Lee 1429 N. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/17/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WM. C. MARCH 928 E. North Ave

SEP 14 1966

Robert E. Johnson

VALLEY FORT

NO CONTENT

USA

1
G-651

66 09278

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09278

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DIANE Cecelia GREMPER

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1966 12:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Reisterstown

D. STREET ADDRESS (If rural, give location)

9 Sunnydale Way

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

April 7, 1949

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

A. Edward F. Grempler

14. MOTHER'S MAIDEN NAME

Betty Culp

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Edward Grempler 9 Sunnydale Way,
Reisterstown, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Cerebrocranial injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Hanover Road 28 feet south
of Kemp Road, Baltimore County

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9-10-66

11:53 P

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Thrown out of car by collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/14/66

23C. NAME OF CEMETERY or CREMATORY

Dulaney Valley Mem. Gardens Cockeysville, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1966

24B. NAME OF REGISTRAR

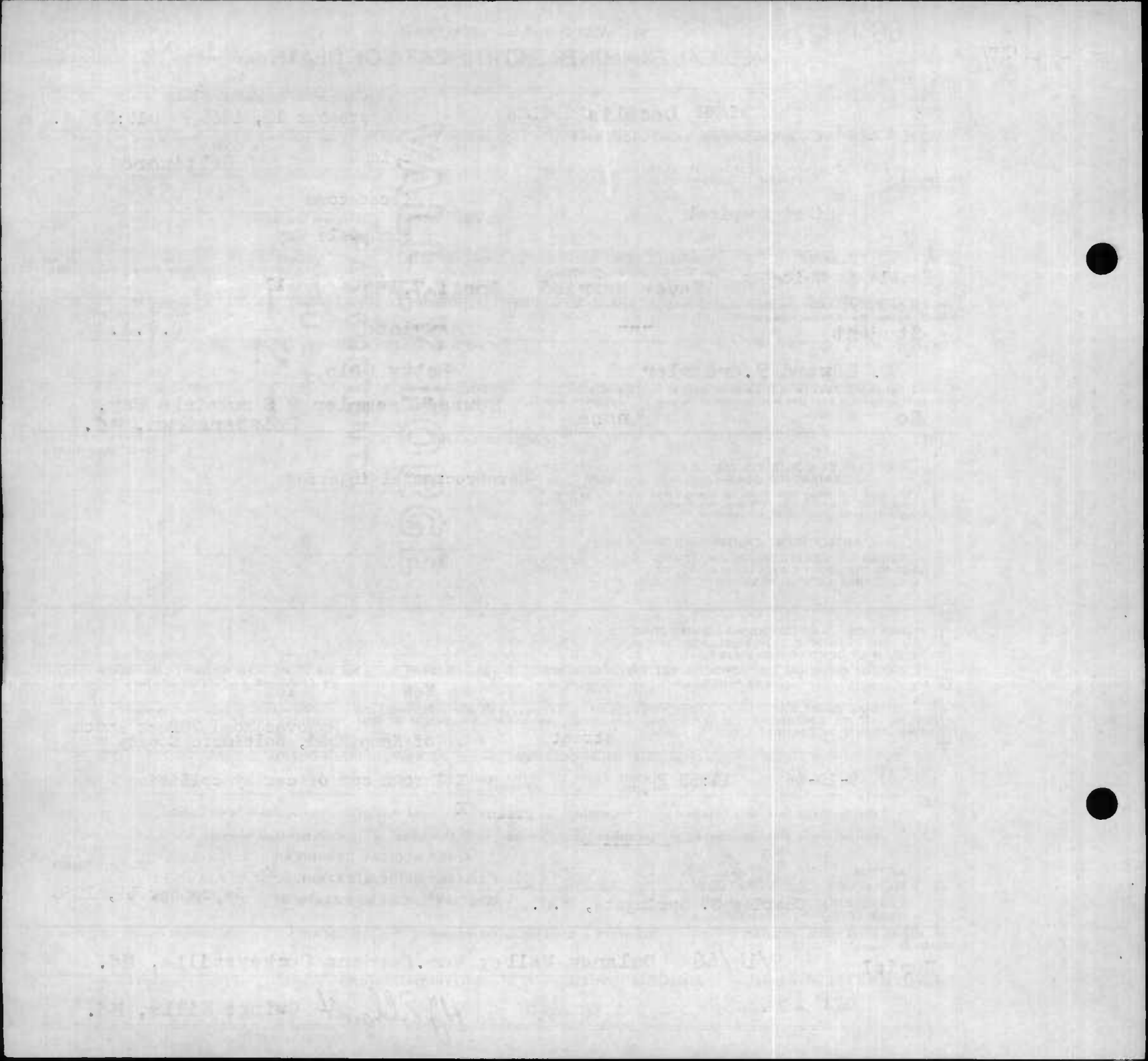
Robert E. Finkbeiner, M.D.

24C. FUNERAL DIRECTOR

H. J. Ehrhardt

ADDRESS

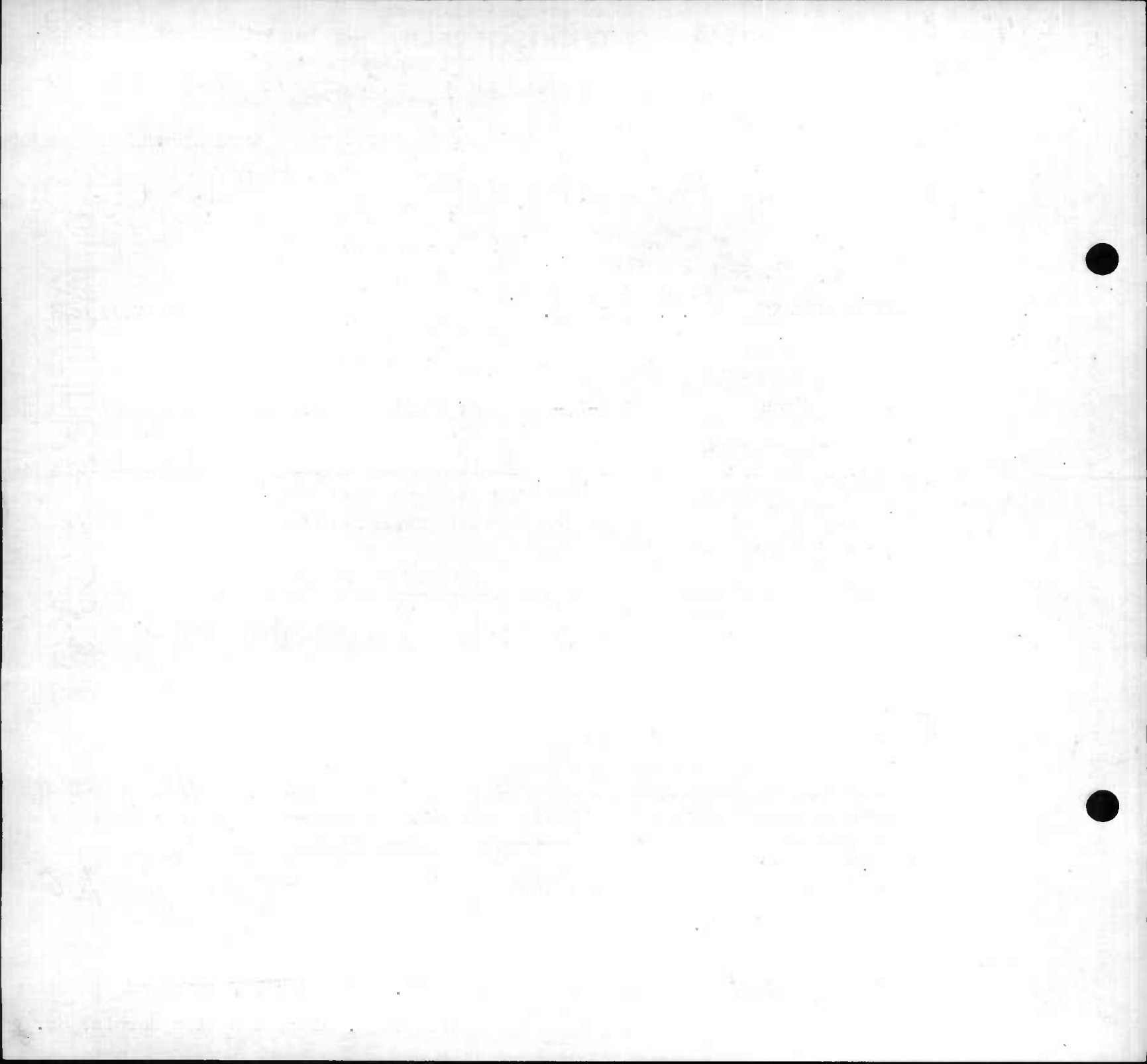
Owings Mills, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|------------------|--|---------------------------------|---|---|
| BIRTH NO. 66 09279 | | CERTIFICATE OF DEATH | | 66 09279 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anthony John Tribulsky | | | |
| 2. DATE AND HOUR OF DEATH | | Sept. 12 1966 5:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Balt. Maryland B. COUNTY Anne Arundel | | | |
| University Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lithicum Heights, Md. | | | |
| | | D. STREET ADDRESS (If rural, give location) 307 Terlyn Ave 52-00 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 7/17/85 | 9. AGE (in years last birthday) 81 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX | | 10B. KIND OF BUSINESS OR INDUSTRY Steelworker (Ret.) A.M. Byer Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | | 12. CITIZEN OF WHAT COUNTRY? unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 167-10-3492 | | 17. INFORMANT ADDRESS Mrs Amelia Mlynarczyk (neice) Same as # 2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Uremia | | unknown | |
| ANTECEDENT CAUSES | | (B) DUE TO Chronic renal disease | | 5 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Pneumonia | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 1) digitoxicity 2) intracerebral bleed | | 1) 3 days 2) 1 wk | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 9/5 19 66 to 9/12 19 66 , that the (we) lost saw the deceased alive on 9/12 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Susan L. Howard | | 23B. DATE SIGNED 9/12/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) SUSAN L. HOWARD | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/66 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk. Glen Burnie, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Richard V. Singleton Glen Burnie, Md. | |



66 09280

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 09280

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LESTER B. CLARK

2. DATE AND HOUR PRONOUNCED DEAD

August 26, 1966 5:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Bar-Wil-Ba Nursing Home
2101 West Coldspring Lane4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1700 Normal Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fracture of Left Femur.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1700 Normal Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 17 '66 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fall on basement floor.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/27/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9/13/66

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, land county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 15 1966

R. L. E. Farley, M.D.

MORTUARY SERVICE - BCHD

VALLEY FRONT

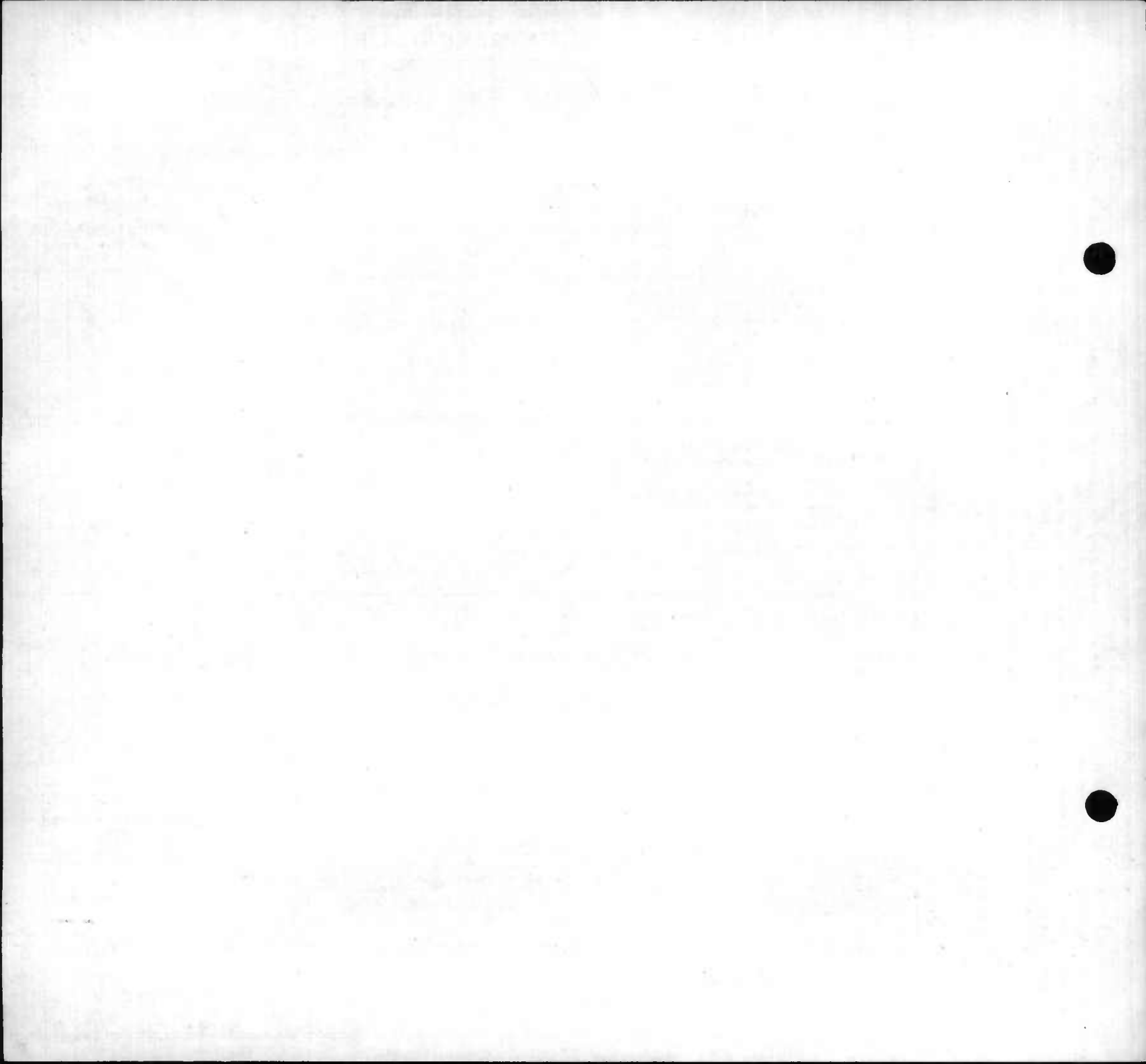
SAN COUSTEIT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09281 | |
|---|------------|--|-------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66-19081-66 09281 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Henderson | | 2. DATE AND HOUR OF DEATH 9-7-66 1 8 ⁴⁰ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | A. STATE MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 418 E Federal ST Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 12-05 | | | |
| 5. SEX F | 6. RACE N. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 9-6-66 | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James Dunbar | | 14. MOTHER'S MAIDEN NAME Madeline Henderson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) DUE TO | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) Immaturity | | 15 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/6 1966 to 9/7 1966, that (I) (we) last saw the deceased alive on 8:40am 9/7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis E. Gruenyer | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) 1 | | | | 23D. ADDRESS MARYLAND HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9/12/66 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR | |
| | | | | 25D. LOCATION | |

BALTIMORE BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



1
J-520

66 09282

BALTIMORE CITY HEALTH DEPARTMENT

66 09282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|--|---------------------------|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) Floyd Jones | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/2/66 9:30 p. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-02 D. STREET ADDRESS (If rural, give location) 704 W. Lexington St. | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) 60 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |

| | | | | | | |
|-----------------------|--|--|---|--|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH I 521 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Abscess of lung and pneumonia, lobar (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) partial | |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| | ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/3/66 | |
| | EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE 9/13/66 | | 23C. NAME OF CEMETERY or CREMATORY | |
| | 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR P. E. & E. Farber, M.D. | | 24C. FUNERAL DIRECTOR | |
| | | | | | 24D. LOCATION (City, town or county) BALTIMORE | |

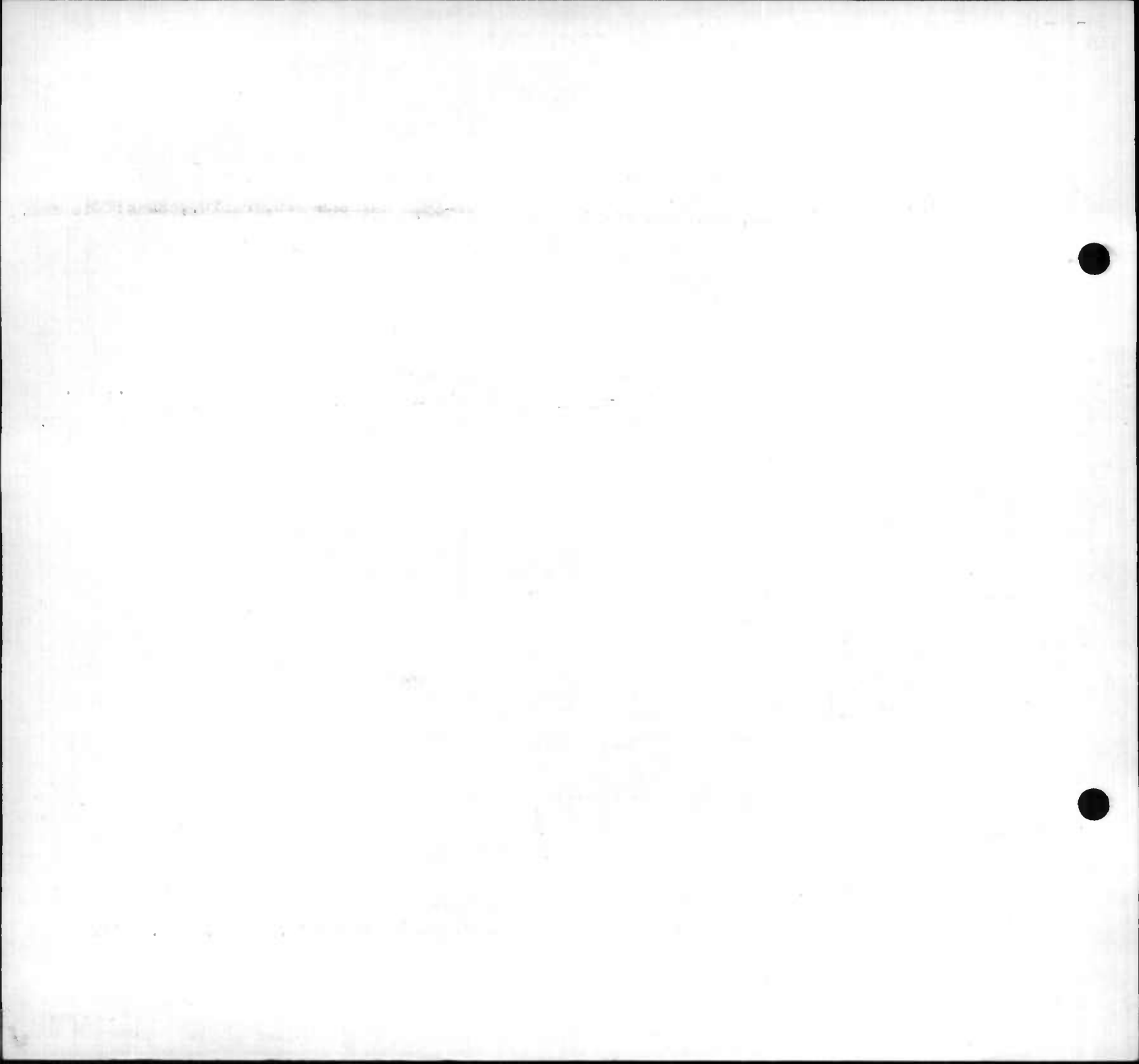
SEP 15 1966

MORTUARY SERVICE - BCHD

VALLEY FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09283 | |
|---|----------------------|--|------------------|---|-----------------------------|
| BIRTH NO. 66 09283 | | CERTIFICATE OF DEATH | | 66 09283 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Vogel, William</i> | | 2. DATE AND HOUR OF DEATH <i>8-28-66 4:00 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE, MARYLAND 21224</i> | | D. STREET ADDRESS (If rural, give location) <i>BCH-4940 EASTERN AVE, BALTO., MD 21224</i> | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) <i>67</i> | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>579-20-5681</i> | | 17. INFORMANT ADDRESS <i>RECORDS-BCH 4940 EASTERN AVE. BALTO., MD. 21224</i> | |
| 18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-18</i> 19 <i>62</i> to <i>8-28</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8-28</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Ross T. Krueger</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>8-28-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Ross T. Krueger</i> | | M.D. 23D. ADDRESS <i>BCH 4940 EASTERN AVE. BALTO., MD. 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>9/12/66</i> | | 24C. NAME OF CEMETERY <i>ANATOMY BOARD OF MARYLAND</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 15 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Folsom</i> | | 25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL</i> | |
| | | | | 25D. LOCATION <i>MORTUARY SERVICE - BCHD</i> | |



R-152

66 09284

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09284

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT

RUBINSTEIN

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1966

12:57 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4210 Fourth Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Aug 23, 1939

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stock Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Rubenstein

14. MOTHER'S MAIDEN NAME

Harriett Woomer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|-------------------------------------|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) Multiple Traumatic Injuries DUE TO | | |
| (B) DUE TO | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| (C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|--|--|--|---|---|
| 2 | | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| | | Street | East Bound On Wilkens Avenue 25-41 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) (Min.) 9 12 '66 10:30 | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | Deceased was passenger Driver struck an electric pole. | |

| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
|--|--|
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED | |
| 9/13/66 | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | |
| Rudiger Breitenecker | |

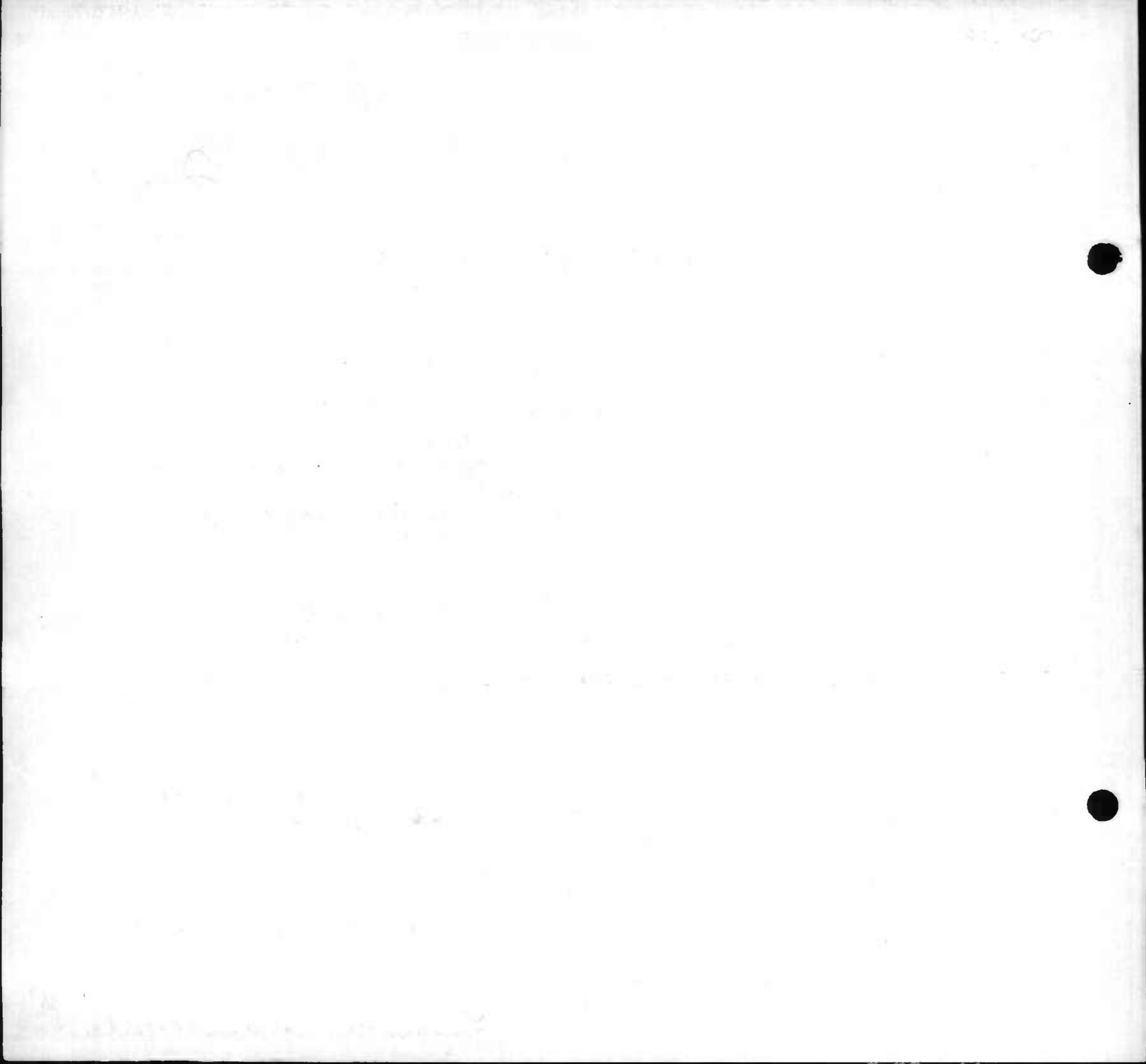
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) | (State) |
|---|-----------|------------------------------------|--|---------|
| Burial | 9/17/66 | Cedar Hill Cem | AA Cb | Md |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR | |
| SEP 15 1966 | | Robert E. Fairley, M.D. | McCully FH 237 Patapsco Ave 21225 | |

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 66 09285 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09285 | |
| 1. NAME OF DECEASED (Type or Print) <i>Gunter, David</i> | | | 2. DATE AND HOUR OF DEATH <i>Sept. 11, 1966 8⁰⁰ A.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-01</i> D. STREET ADDRESS (If rural, give location) <i>4223 White Avenue</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i> <i>42</i> | | (If not in hospital or institution, give street address or location) | | | |
| 5. SEX <i>M.</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>8/3/90</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad crew</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Md.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 13. FATHER'S NAME <i>Unknown James Gunter</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | |
| 16. SOCIAL SECURITY NO. <i>705-09-1812</i> | | | 17. INFORMANT ADDRESS <i>Hospital Records</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Bilateral Bronchopneumonia</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Anteroselected Cardiovascular Disease</i> | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Recent gangrenous gall bladder & abscess & surgical drainage</i> | | | | | |
| 19A. DATE OF OPERATION <i>7/25/64</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrenous gall bladder</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 5</i> 19 <i>64</i> to <i>Sept 11</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept 10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Isadore K. Grossman</i> M.D. | | | 23B. DATE SIGNED <i>9/11/66</i> | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) <i>Isadore K. Grossman</i> M.D. | | | 23D. ADDRESS <i>1527 E. North Ave</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-15-1966</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Meadow Ridge Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 15 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Falek</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Lassahn Funeral Home 9401 Belair Road</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|----------------------------------|--|-------------------------|--|
| K-65066 09286 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09286 | |
| BIRTH NO. 66 09286 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) James B. Kearney | | | 2. DATE AND HOUR OF DEATH 10 Sept 1966 4:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 EASTERN AVE. BALTO., MD. 21224 | | | A. STATE Maryland B. COUNTY Baltimore | | |
| 5. SEX Male | | | 6. RACE Negro | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | 8. DATE OF BIRTH 7/12/31 | | |
| 9. AGE (In years last birthday) 35 | | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY Railroad | | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Morris Kearney | | | 14. MOTHER'S MAIDEN NAME Vivian Parris | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 239-44- | | |
| 17. INFORMANT BCH | | | ADDRESS RECORDS-4940 EASTERN AVE. BALTO., MD. 21224 | | |
| 18. 581.0 I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO Respiratory Arrest. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO Ascites | | |
| | | | (C) Severe Cirrhosis | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Malabsorption & Anemia | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) YES | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that the (this hospital) attended the deceased from 25 July 1966 to 10 Sept 1966 , that the (we) last saw the deceased alive on 10 Sept 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dudley A. Raine Jr. | | | 23B. DATE SIGNED 10 Sept 1966 | | |
| 23C. PHYSICIAN'S NAME (Type) Dudley A. Raine Jr. | | | 23D. ADDRESS BALTO., MD. 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9-14-66 | | |
| 24C. NAME OF CEMETERY OR CREMATORY mt Auburn | | | 24D. LOCATION (City, town, or county) (State) Baltimore md | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | | 25B. NAME OF REGISTRAR Robert E. Faldut | | |
| 25C. FUNERAL DIRECTOR Marshall Upfresh | | | ADDRESS 1735 Harford Ave. | | |

Delivered 11/14/11

10/24/11

10/24/11

10/24/11

10/24/11

Washington & Adams

2-2-11

2-2-11

Registered Agent

Vision Pro

North Carolina

2/12/11

1344 Ford St

Charlotte

10/24/11

Worlds Recovery

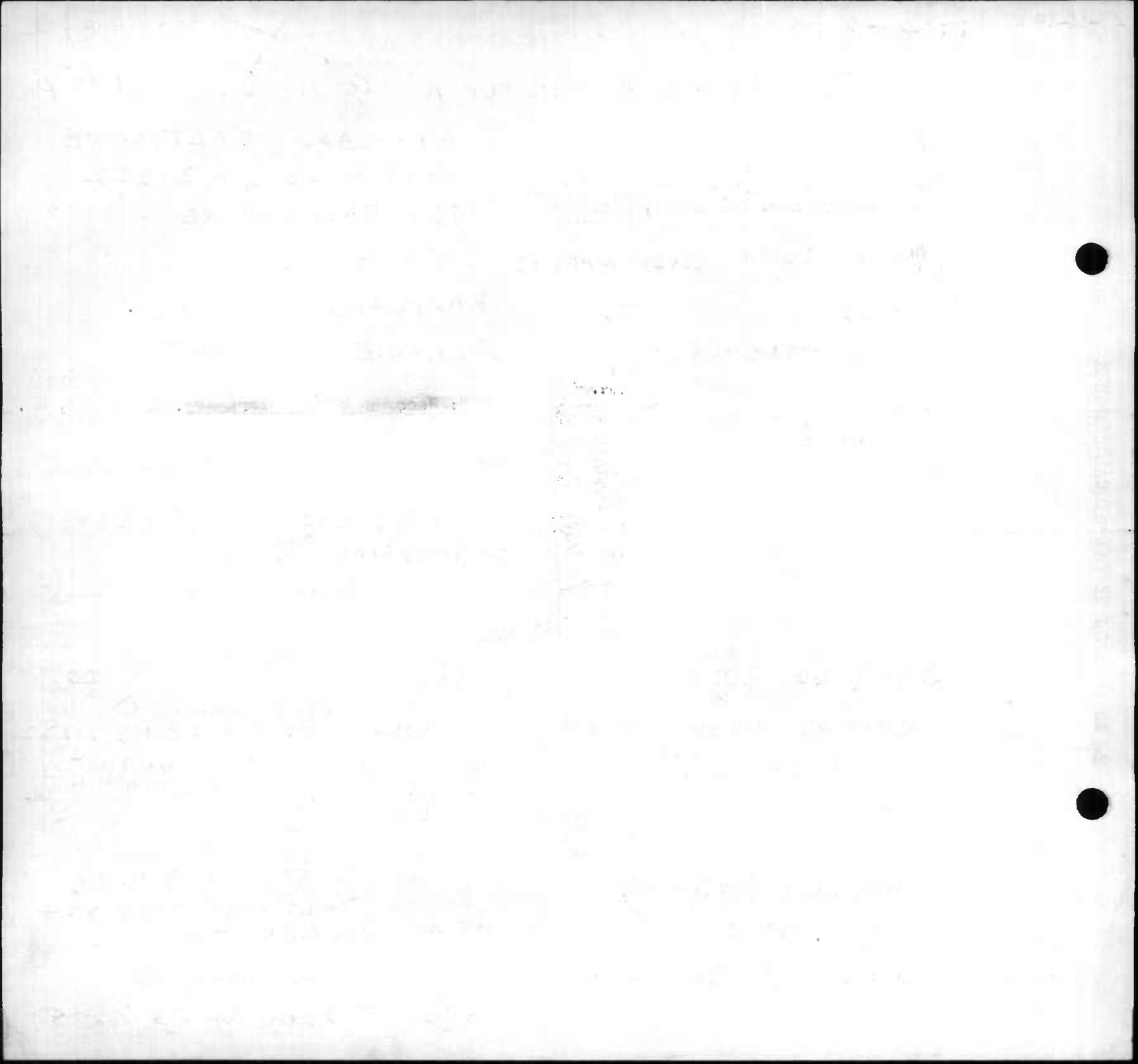
Mr. Wayne

TO BE APPROVED BY THE MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 64-12849 66 09287 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09287 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) TODD FREDERICK HONCHURUK | | 2. DATE AND HOUR OF DEATH 9-11-66 11 15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21222 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1923 JASMINE RD 53-00 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 5-17-64 | 9. AGE (In years lost birthday) 2 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME FRED HONCHURUK | | 14. MOTHER'S MAIDEN NAME MELANIE WRIGHT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPSIS | | INTERVAL BETWEEN ONSET AND DEATH 24 HOURS | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 35% TOTAL BODY 30 THERMAL BURN | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION 9-7-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BURN | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NOTIFIED 9-11-66 | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME 1923 JASMINE RD BALTIMORE, MD, 21222 | |
| 21D. TIME OF INJURY (APPROX.) 8-24-66 7AM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? CLIMBED ON STOVE IGNITING CLOTHING | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-24-66 to 9-11-66 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas J. Krizeck | | | | 23B. DATE SIGNED 9-11-66 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Krizeck | | | | 23D. ADDRESS BALTIMORE, MD, 21224 4940 EASTERN AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR John F. Denny, Inc. 715 Light St. | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |

SEP 15 1966



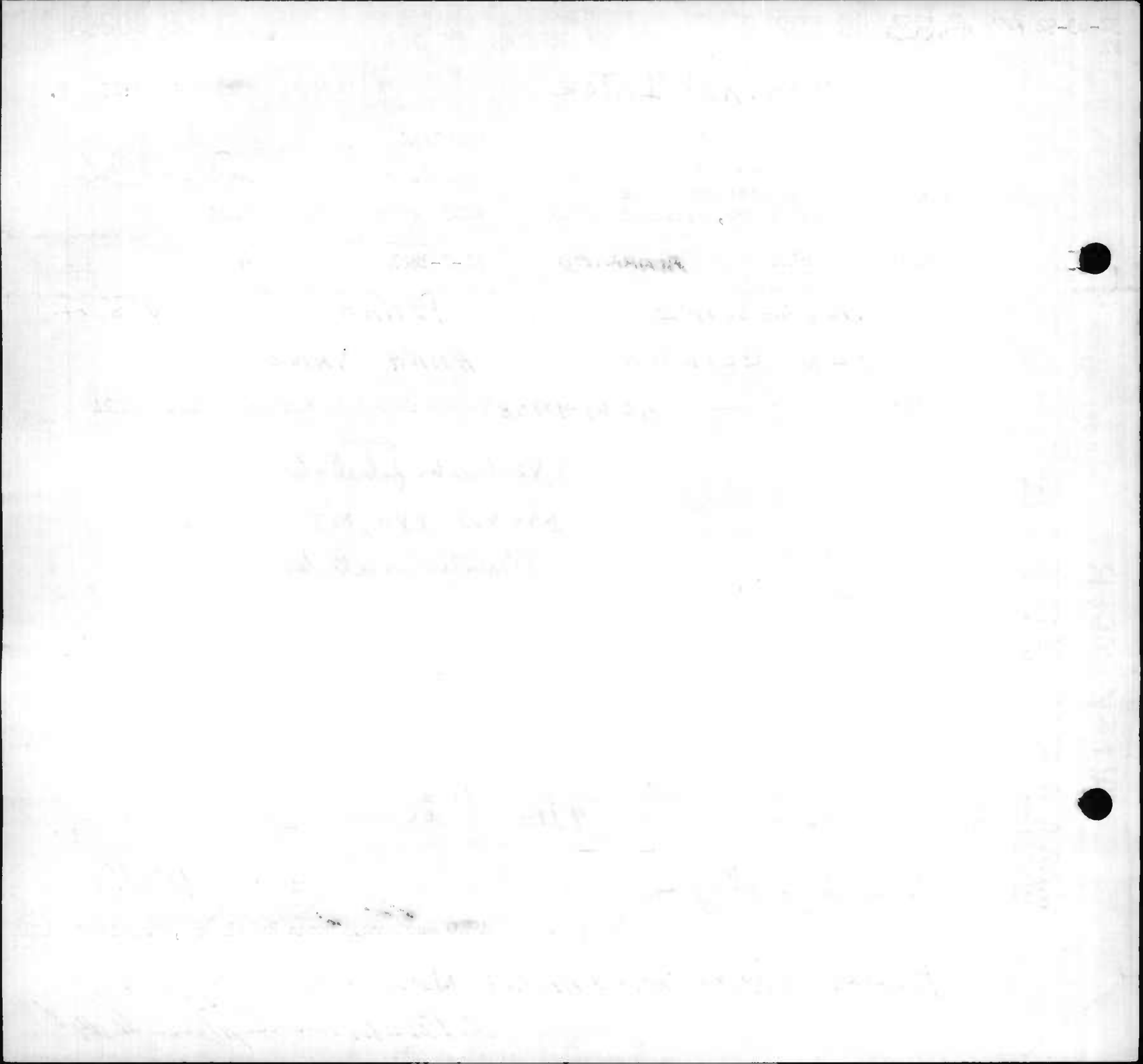
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09288

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. MAY | | 1. NAME OF DECEASED (Type or Print) MARY McINTee | | 2. DATE AND HOUR OF DEATH 9/12/66 4:25 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY Baltimore | |
| 5. SEX Female | | | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | | 8. DATE OF BIRTH 11-2-1881 | |
| 9. AGE (In years last birthday) 84 | | | | 10. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 11. BIRTHPLACE (State or foreign country) PENNA | |
| 13. FATHER'S NAME JOHN CLINTON | | | | 14. MOTHER'S MAIDEN NAME ANNA VANCE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-09-43838 | |
| 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 19 66 to 9/12 19 66, that (I) (we) last saw the deceased alive on 9/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Terry Ersel Gagon | | | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) Terry Ersel Gagon | | | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 9/16/66 | |
| 24C. NAME OF CEMETERY OR CREMATORY SACRED HEART - JESUS | | | | 24D. LOCATION (City, town, or county) (State) BALTO. CO., MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



66 09289

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 09289

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUBIN C. SNOW

2. DATE AND HOUR PRONOUNCED DEAD

September 10, 1966

12:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

91 Montebello Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Harve De Grace

D. STREET ADDRESS (If rural, give location)

229 N. Union Ave.,

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

May 15-1906

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY

Apartment House

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

??

17. INFORMANT

Rozabya D. Carlson,

ADDRESS

229 N. Union Ave.

Harve de Grace, Maryland

| | | | | | |
|--|--|--|--|---|--|
| 18. <u>177X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) Adenocarcinoma of prostate with metastases | | | |
| | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 21D TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |

MEDICAL CERTIFICATION

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

CREMATION

23B. DATE

Sept. 12-1966

23C. NAME of CEMETERY or CREMATORY

Greenmount Crematorium

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1966

24B. NAME OF REGISTRAR

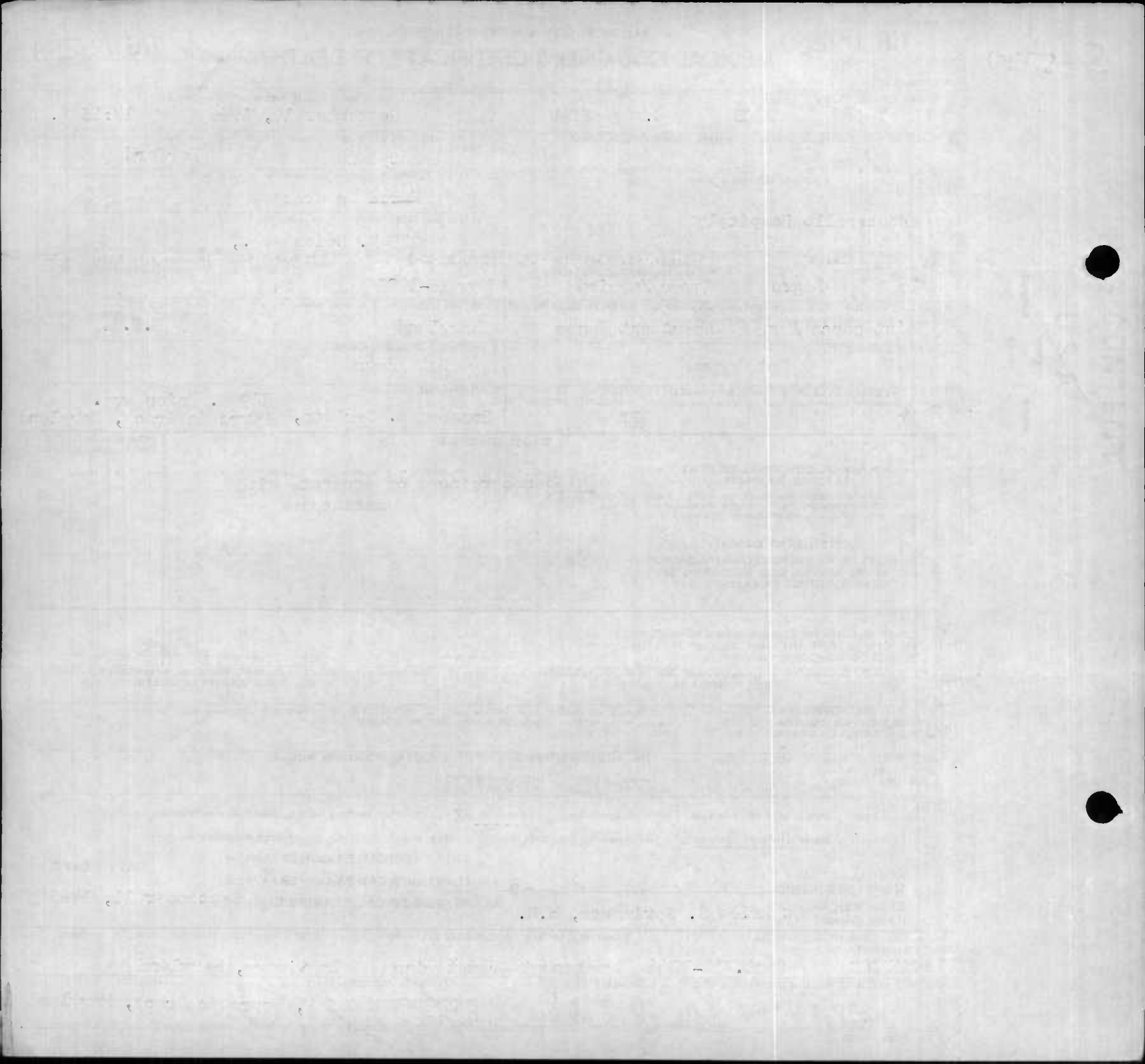
Robert E. Fairbank

24C. FUNERAL DIRECTOR

PERRINGTON & SON

ADDRESS

Harve de Grace, Maryland



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| RELEASED ON APPROVAL | | BALTIMORE CITY HEALTH DEPARTMENT | | Certificate of Death | | Registered No. 66 09290 | |
|---|--|----------------------------------|--|---|--|---|--|
| BIRTH NO. 66 09250 | | M.E. CASE NO. 66 09250 | | 1. NAME OF DECEASED (Type or Print) DORSEY, GEORGE | | 2. DATE AND HOUR OF DEATH 9-13-66 10 ³⁰ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland, Inc. | | | | 6. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-04 | | | |
| 7. STREET ADDRESS (If rural, give location) 2020 W. NORTH AVENUE | | | | 8. DATE OF BIRTH 1-28-82 9. AGE (In years last birthday) 84 | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | | | | 11. BIRTHPLACE (State or foreign country) U.S. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS Sadie Dorsey 2020 W. North Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH First + 2nd degree Burns | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 14 days. | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Possible Arteriosclerotic CA, Coronary Insufficiency | | | |
| 21. DATE OF OPERATION | | | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | | |
| 25. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-2-66 10 ⁰⁰ | | | | 26. WHERE DID INJURY OCCUR? In 2020 W. North Ave. Baltimore | | | |
| 27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | 28. HOW DID INJURY OCCUR? fire + sustained 2nd degree burns | | | |
| 29. I certify that (I) (this hospital) attended the deceased from 9-2-66 to 9-13-66 | | | | 30. that (I) (we) last saw the deceased alive on 9-13-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 31. SIGNATURE S. Mamaril Jr. | | | | 32. DATE SIGNED 9-13-66 | | | |
| 33. PHYSICIAN'S NAME (Type) A. MAMARIL JR. | | | | 34. ADDRESS Lutheran Hospital | | | |
| 35. BURIAL CREMATION, REMOVAL (Specify) B | | | | 36. DATE 9-17-66 | | | |
| 37. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | | | 38. LOCATION (City, town, or county) (State) Balt. Co. Md. | | | |
| 39. DATE REC'D BY HEALTH DEPT. | | | | 40. NAME OF REGISTRAR | | | |
| 41. FUNERAL DIRECTOR Sullivan Funeral Home - 10115 1/2 Arlington Ave | | | | 42. ADDRESS | | | |

10-13-45

10-13-45

10-13-45

2020 W NORTH AVENUE
 BOSTON, MASS
 1-25-45
 24

Lutheran Hospital of
 Boston, Inc

1-25-45
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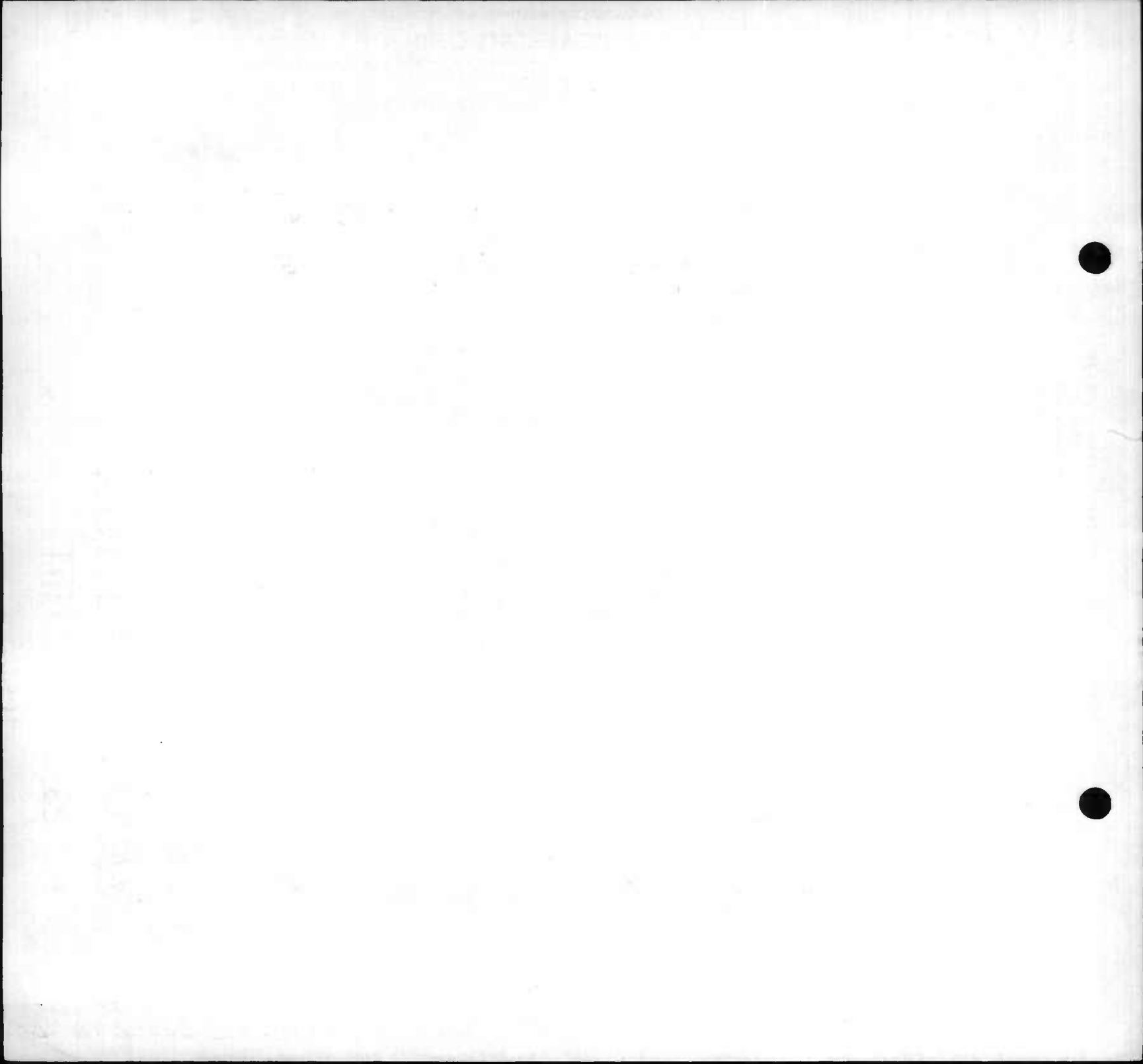
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 10-13-45

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|--|--|--|
| BIRTH NO. 66 09291 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09291 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) SOPHIA HRUBES | | | 2. DATE AND HOUR OF DEATH 9-12-66 1:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Church Home & Hosp. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-02 D. STREET ADDRESS (If rural, give location) 103 N. GLOVER ST 29 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 9-4-01 | 9. AGE (In years last birthday) 65 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John FehL | | 14. MOTHER'S MAIDEN NAME Christina Hotokech | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT chant | |
| 18. ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 199.2 I Metastatic Carcinoma, site undetermined | | | INTERVAL BETWEEN ONSET AND DEATH days? | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Arteriosclerotic Heart Disease & Cong. Heart failure | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-12 19 66 to 9-12 19 66 that (I) (we) last saw the deceased alive on 9-12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | 23B. DATE SIGNED 9-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) A. E. SUBONG, SR. M.D. | | | | 23D. ADDRESS Church Home & Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/16/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Faldana | | 25C. FUNERAL DIRECTOR John A. Moran, Inc | |
| 25D. ADDRESS 3000 E. Baltimore | | | | | |



66 09292

66 09292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Wood

2. DATE AND HOUR PRONOUNCED DEAD

9-9-66 7:28 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2034 Edmondson Ave, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2034 Edmondson Ave.

5. SEX

M

6. RACE

N

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/4/39

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Richard Woods

14. MOTHER'S MAIDEN NAME

Sylvia Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

214-38-6768

17. INFORMANT

ADDRESS

Mrs Sylvia Woods, 2034 Edmondson Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stabwound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2034 Edmondson Ave.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

9-9-66, about 7:25p.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Presumably stabbed during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-10-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/13/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 15 1966 R. B. E. Fickens

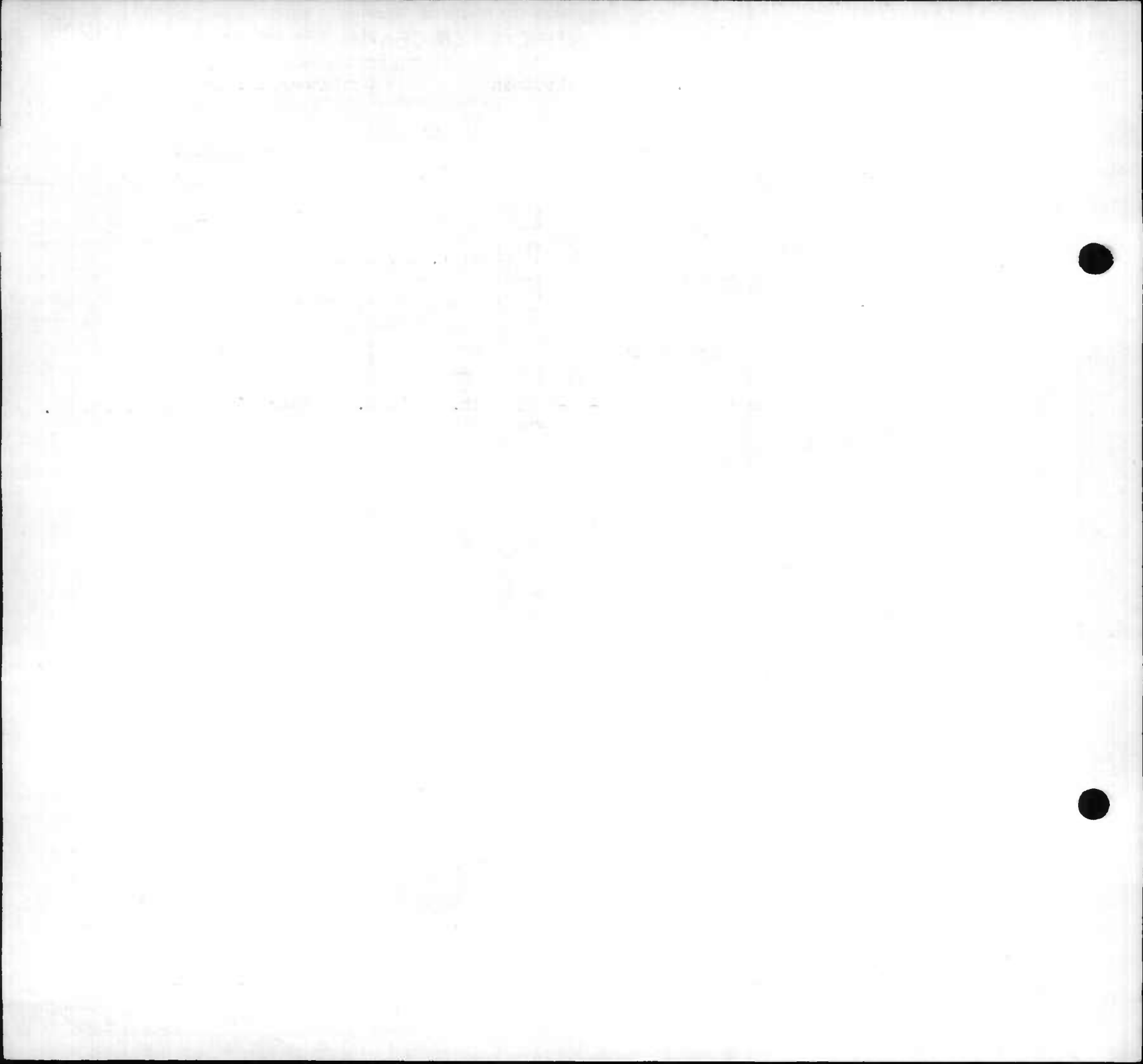
Adolphus Halstead 1206 W North Ave

VALLEY FORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

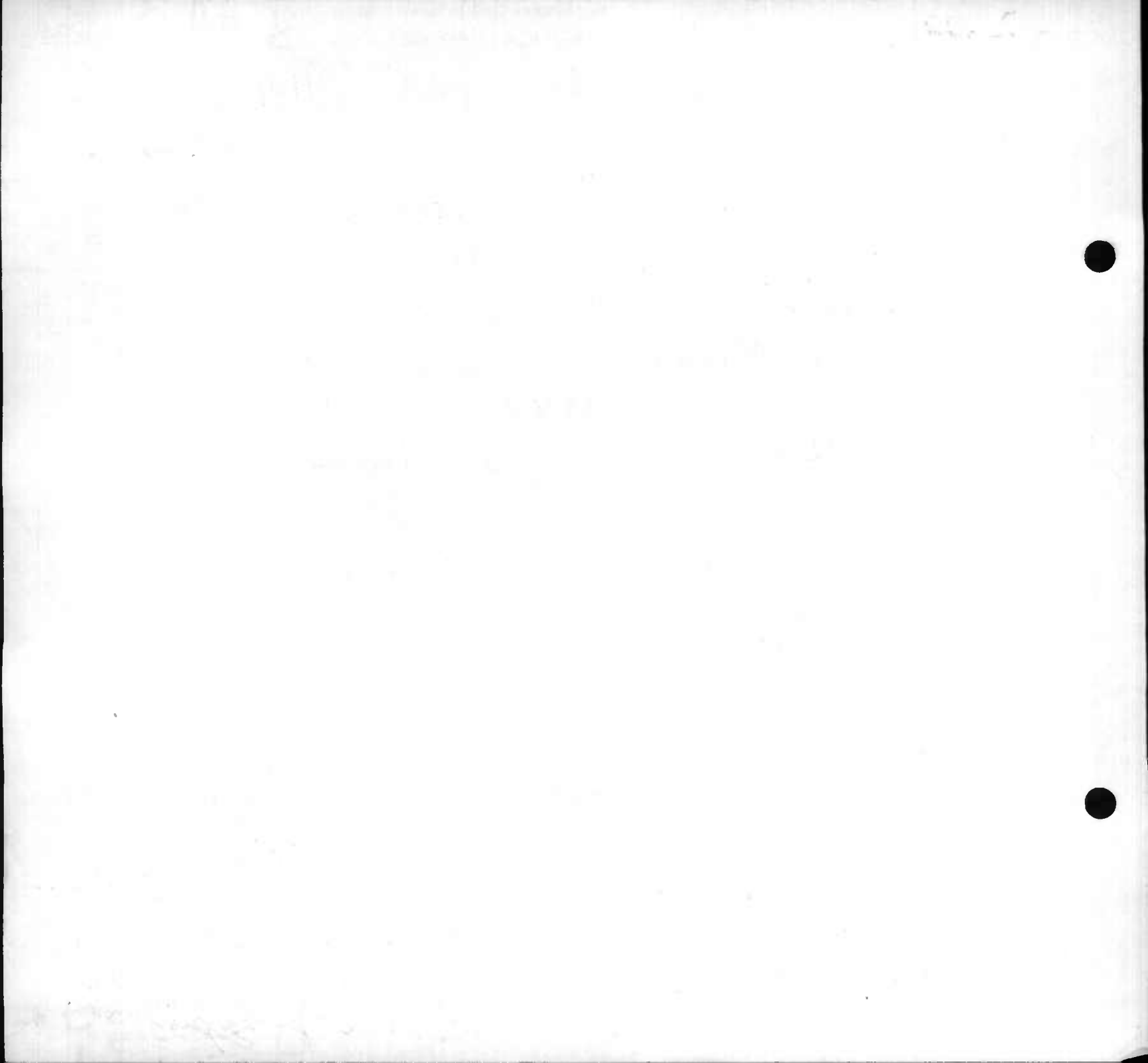
| | | | | | |
|--|------------------|---|--|---|---|
| BIRTH NO. 66 09293 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09293 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Anna S. Kaufman | | September 13, 1966 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nursing Home | | | | A. STATE Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 3800 Menlo Drive 15 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Sept. 18, 1871 | 9. AGE (In years last birthday) 94 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Sauerwald | | | 14. MOTHER'S MAIDEN NAME Worth | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 220-54-7273 | 17. INFORMANT Mr. Irvin S. Kaufman 2433 Brambleton Rd. | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Coronary Artery Disease</i> DUE TO (B) <i>MI</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/6/66</u> 19 to <u>9/6</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/6/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Wilson</i> | | | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) WILSON | | | | 23D. ADDRESS 5721 Park Heights | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/14/1966 | | 24C. NAME of CEMETERY or CREMATORY Hebrew Friendship Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Wm J. Wilson & Sons | |
| | | | | ADDRESS Baltimore, Md. North Pa. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|--|--|---|--|--|--|--|
| BIRTH NO. 66 09294 | | | | | CERTIFICATE OF DEATH | | | Registered No. 66 09294 | |
| 1. NAME OF DECEASED (Type or Print) HUGHES Dorothy Elizabeth | | | | | 2. DATE AND HOUR OF DEATH 9/10/66 2⁰⁰ P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17-02 | | | | |
| D. STREET ADDRESS (If rural, give location) 1313 Brun St | | | | | | | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | | | 8. DATE OF BIRTH 12/12/09 | 9. AGE (In years last birthday) 56 | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Edward Mackall | | | | | 14. MOTHER'S MAIDEN NAME Matilda TALBOTT | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 219-09-0852 | | 17. INFORMANT ADDRESS record | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Ca of Cervic DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 14 | |
| | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? 9/9 1966 9/10 1966 | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 1966 to 9/10 1966 , that (I) (we) last saw the deceased alive on 9/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE H. Baune Mann | | | | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) H. BAUNE MANN M.D. | | | | | 23D. ADDRESS University Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9-14-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | | 25B. NAME OF REGISTRAR Robert E. Fink | | | 25C. FUNERAL DIRECTOR'S ADDRESS Garrie V. Cooper 512 N. Carrollton Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|---|--|---|
| BIRTH NO. 66 09295 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09295 | |
| 1. NAME OF DECEASED (Type or Print) Frieda M. Zinnert | | | 2. DATE AND HOUR OF DEATH Sept. 13, 1966 9 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 237 S. Gilmor St. Baltimore, 23, Md. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1903 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 237 S. Gilmor St. | | |
| 5. SEX F | 6. RACE Wh | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 2-8-91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Otto B | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-32-7598 | 17. INFORMANT Elsie Dehne | | ADDRESS 2511 Christian St. - #23 |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO Age | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 1956 to Sept. 14, 1966 , that (I) (we) last saw the deceased alive on August 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Morris B. Schrieber | | | | 23B. DATE SIGNED 9-14-66 | |
| 23C. PHYSICIAN'S NAME (Type) Morris B. Schrieber | | | | 23D. ADDRESS 1519 W. Lombard St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-16-66 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Av. | |

1870-1871

1871-1872

1872-1873

1873-1874

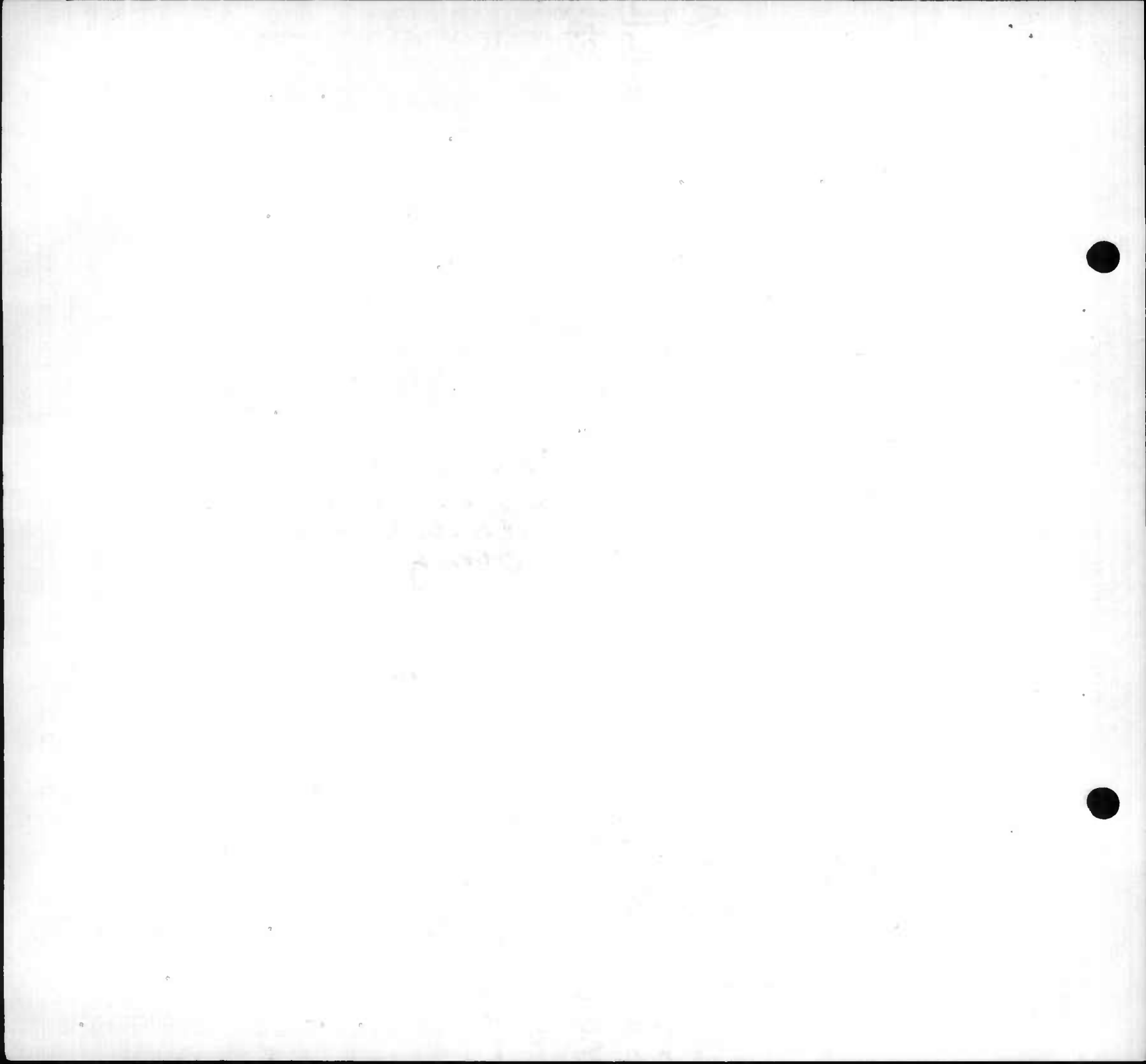
1874-1875

1875-1876

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|--|--|---|--|
| BIRTH NO. 66 09296 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09296 | |
| 1. NAME OF DECEASED (Type or Print) Sarah Sanphillipo | | | 2. DATE AND HOUR OF DEATH Sept. 12, 1966 3:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 148 S. Hilton St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 20-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 148 S. Hilton St. | | |
| 5. SEX F | 6. RACE Wh | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Apr. 26, 1966 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Late-Salvatore Cascio | | | 14. MOTHER'S MAIDEN NAME Late - Catherine | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Michael Sanphillipo 1219 Stamford Rd. - #7 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 287X1 Myocardial Insufficiency Hypertensive & arteriosclerotic Cardio Vascular Disease Obesity | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| <div style="display: flex; justify-content: space-between;"> <div> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div> <p>19A. DATE OF OPERATION 0</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> </div> <div> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> </div> <div> <p>20A. AUTOPSY? (Yes or No) no</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21F. HOW DID INJURY OCCUR?</p> </div> <div> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> </div> </div> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 24, 1957 to Sept. 12, 1966 , that (I) (we) last saw the deceased alive on June 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Cleared & Medical Examiner | | | | | |
| 23A. SIGNATURE Harry Knipp | | | 23B. DATE SIGNED 9-13-66 | | |
| 23C. PHYSICIAN'S NAME (Type) Harry Knipp | | | 23D. ADDRESS 4116 Edmondson Av. Baltimore 29, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-14-66 | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Farkas | | 25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09297

BIRTH NO. 66 09297

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Gladys Bowen

2. DATE AND HOUR OF DEATH

Sept. 13, 1966 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

515 Brunswick Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9/3/13

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Joseph Curran

14. MOTHER'S MAIDEN NAME

Catherine McDermott

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mary O'Neill

ADDRESS

138 N. Grove Angle Rd. - Ellicott City

18. 581.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Shock 20 gram negative Strep.
sepsis and/or acidosis
Chronic heart disease, many
years
UTI's

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-28- 19 66 to 9-13- 19 66,
that (I) we last saw the deceased alive on 9-13 19 66 and that in (my) our opinion death occurred on the date
and hour and from the causes stated above. (I) We (did) did not view the body after death.

23A. SIGNATURE

David S. Fedson

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

Sept 13, 1966

23C. PHYSICIAN'S
NAME (Type)

David Fedson

M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-16-66

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 15 1966

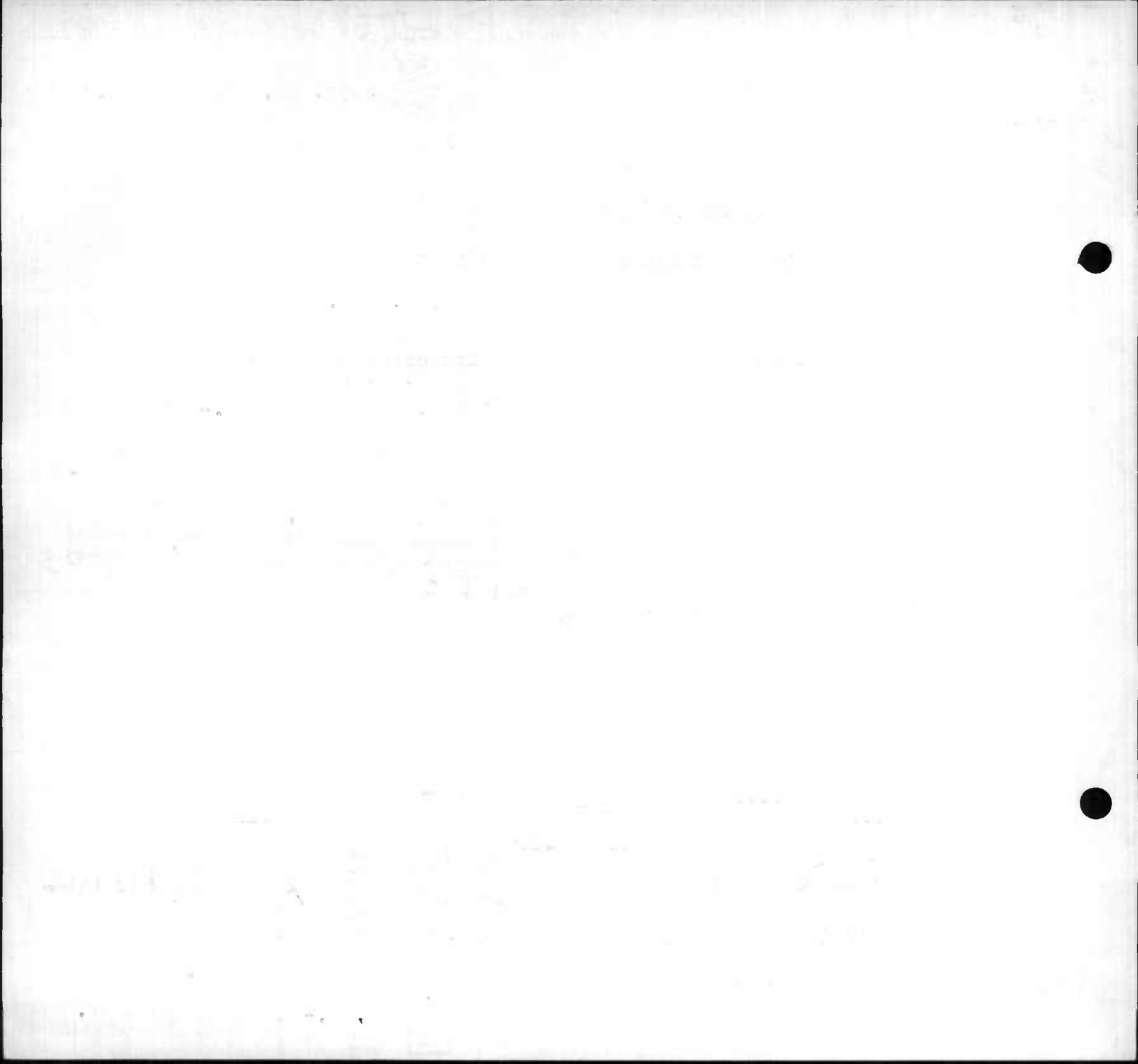
25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Witzke, F. D. - 4101 Edmondson Av.

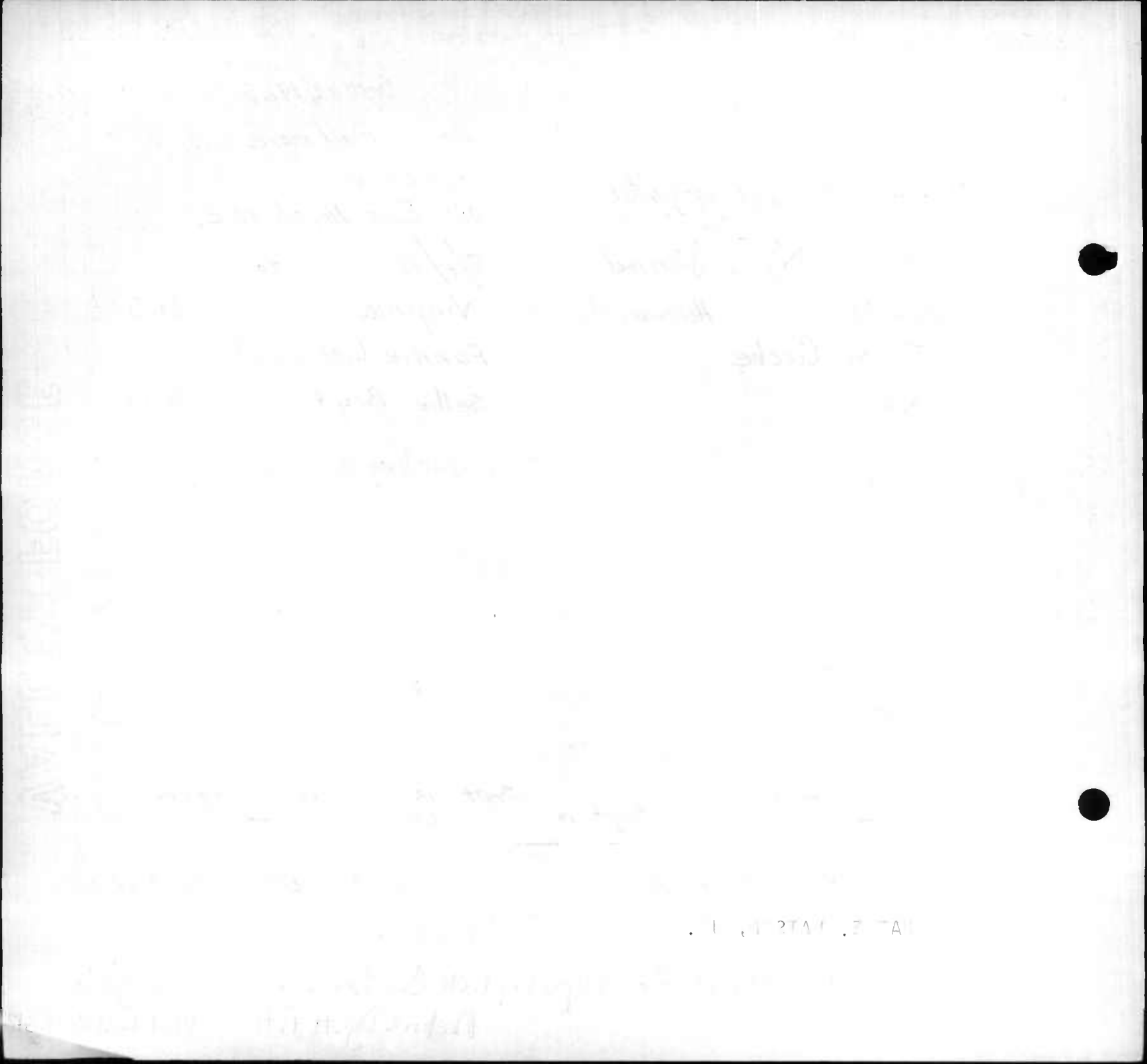
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09298 | |
|--|---------------------|---|-----------------------------------|---|---|
| BIRTH NO. 66 09298 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Alma Boyd</u> | | 2. DATE AND HOUR OF DEATH <u>Sept 14, 1966</u> <u>16:30 A.</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>902 East North Ave.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>7/2/18</u> | 9. AGE (In years last birthday) <u>48</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Joseph Goobe</u> | | 14. MOTHER'S MAIDEN NAME <u>Fannie (unknown)</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Sellie Boyd</u> | |
| | | | | ADDRESS <u>Same</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>330X I</u> | | CAUSE OF DEATH (A) <u>Subarachnoid hemorrhage</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>66</u> to <u>Sept 14</u> 19 <u>66</u> . that (I) was lost saw the deceased alive on <u>Sept 14</u> 19 <u>66</u> and that in (my) was opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE <u>Nat E. Watson, Jr.</u> | | | | 23B. DATE SIGNED <u>Sept 14, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NAT E. WATSON, JR.</u> | | | | 23D. ADDRESS <u>Laurensville</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-17-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Good Hope Bp't. Ch. Cem. Law Rencevi 11e, Virginia</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>1701 Laurens St.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u> | |
| | | 25C. FUNERAL DIRECTOR <u>Morton Dyett F. H.</u> | | ADDRESS <u>1701 Laurens St.</u> | |



A-450

66 09299

BALTIMORE CITY HEALTH DEPARTMENT

66 09299

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM HENRY ALLEN, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

September 13 - 66 1:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3038 Arunah Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3038 Arunah Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4-12-1909

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY

BA HCo. City

11. BIRTHPLACE (State or foreign country)

SPARROWS PT., Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WM H. ALLEN

14. MOTHER'S MAIDEN NAME

Virgie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-18-4091

17. INFORMANT

Meredith ALLEN

ADDRESS

3038 ARUNAH AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type) Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-17-66

23C. NAME of CEMETERY or CREMATORY

ARbutus

23D. LOCATION

Arbutus

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1966

24B. NAME OF REGISTRAR

Rudiger E. Breitenecker

24C. FUNERAL DIRECTOR

MORTON J. Dwyer F.H. 1761 LAURENS

ADDRESS

WALTER
CLING

1914-1915
W. H. H. H. H.
W. H. H. H. H.

1914

1914-1915
W. H. H. H. H.
W. H. H. H. H.

BIRTH NO.

66 09300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL CLAY

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1966 7:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1512 Argyle Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb 6, 1943

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

D-Brown Shoe

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel Clay Sr.

14. MOTHER'S MAIDEN NAME

Laura Herbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

214-40-2381

17. INFORMANT

Mrs. Laura Clay

ADDRESS

1512 Argyle Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive Internal Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Multiple gunshot wounds of chest
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Pavement in front of 1413 Ave. Pennsylvania

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 12 66 7:40 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/13/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-17-66

23C. NAME OF CEMETERY OR CREMATORY

MT. CALVARY

23D. LOCATION

A.A. Co.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 15 1966

24B. NAME OF REGISTRAR

Rudiger E. Breitenacker

24C. FUNERAL DIRECTOR

Morton E. Dyett F.H.

ADDRESS

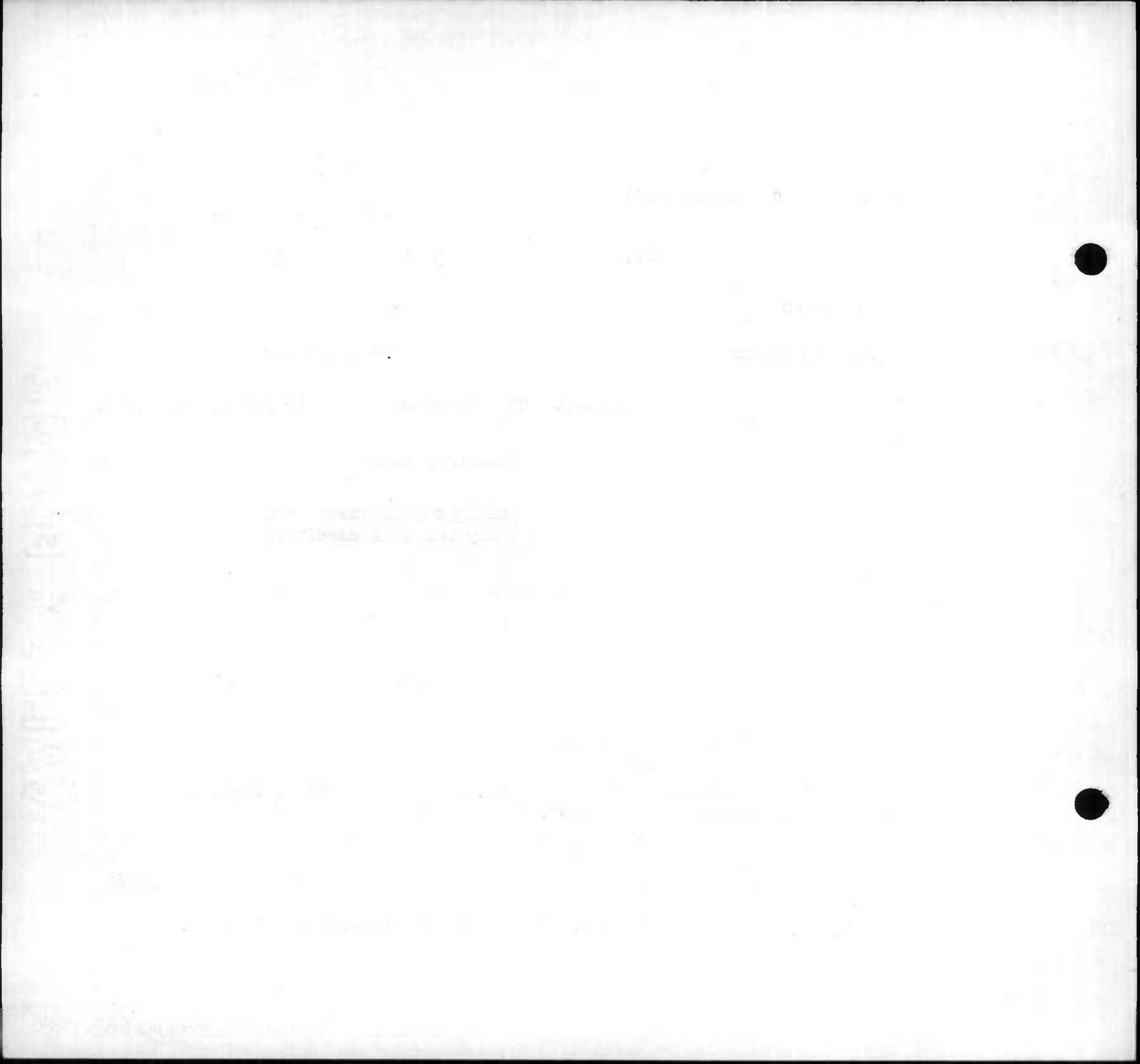
1701 Laurens St.

WALL STREET JOURNAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09301 | |
|---|---------------------|--|-----------------------------------|--|---|
| BIRTH NO. 66 09301 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Everette Owen Madison | | 2. DATE AND HOUR OF DEATH Sept. 12, 1966 7 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | A. STATE Va. | | B. COUNTY 1-43 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Roanoke | | | |
| | | D. STREET ADDRESS (If rural, give location) 1212 Franklin Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Div. | 8. DATE OF BIRTH 9/3/26 | 9. AGE (In years last birthday) 40 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Eugene Madison | | 14. MOTHER'S MAIDEN NAME Katie Sanderson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 224-24-9170 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 178X I Pulmonary edema | | CAUSE OF DEATH (A) DUE TO Multiple metastases from embryonal cell carcinoma | | INTERVAL BETWEEN ONSET AND DEATH Days Year | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 1 1966 to Sept. 12 1966 , that (I) (we) last saw the deceased alive on Sept. 12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael E. Pelczar M.D. | | | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (R) M.D. | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 9/15/66 Longwood | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY or CREMATORY Bedford Co Va | |
| 24D. LOCATION (City, town, or county) (State) Bedford Co Va | | 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR Witzke | | 25D. ADDRESS 4101 Edmondson Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| | | | | | |
|--|---|---|--|---|---|
| BIRTH NO. 66 09302 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09302 | |
| 1. NAME OF DECEASED (Type or Print) Thayes V. Brown | | | 2. DATE AND HOUR OF DEATH Sept. 12, 1966 7 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1401 W. Ostend St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21-02 D. STREET ADDRESS (If rural, give location) 1401 W. Ostend St. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Dec. 1, 1923 | 9. AGE (In years, lost birthday) 43 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | 13. FATHER'S NAME Carl H. Taylor | | |
| 14. MOTHER'S MAIDEN NAME Olive L. Lewis | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edwin R. Wolfe | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Failure | | | INTERVAL BETWEEN ONSET AND DEATH 2 day | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor Pulmonale | | | 5 days | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumorectomy right | | | | | |
| 19A. DATE OF OPERATION 1959 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tuberculosis | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 19 66 to 9/12 19 66 , that (I) (we) last saw the deceased alive on 9/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE John P. Urlock Jr | | | | 23B. DATE SIGNED 9/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR | | 23D. ADDRESS 1227 Washington Blvd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9 15 1966 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1966 | | 25B. NAME OF REGISTRAR Robert E. Fickel | | 25C. FUNERAL DIRECTOR Mc Cully | |
| 25D. ADDRESS 130 E. Fort Ave. | | | | | |

Canadian Pacific
Co. Ltd.

Presumptive rights
to

1927

2/10

2/10

2/10

—

—

John P. Green 1927
James D. Green 1927
Washington D.C.

1
P-620

66 09303

BALTIMORE CITY HEALTH DEPARTMENT

66 09303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

YORK

PRICE

2. DATE AND HOUR PRONOUNCED DEAD

September 12, 1966

12:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1113 Somerset Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1113 Somerset Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

12-18-23

9. AGE (In years
last birthday)

72 yrs.

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Refiner

11. BIRTHPLACE (State or foreign country)

Fla.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

260-14-7854

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER H. BROWN

RECEIVED

1934

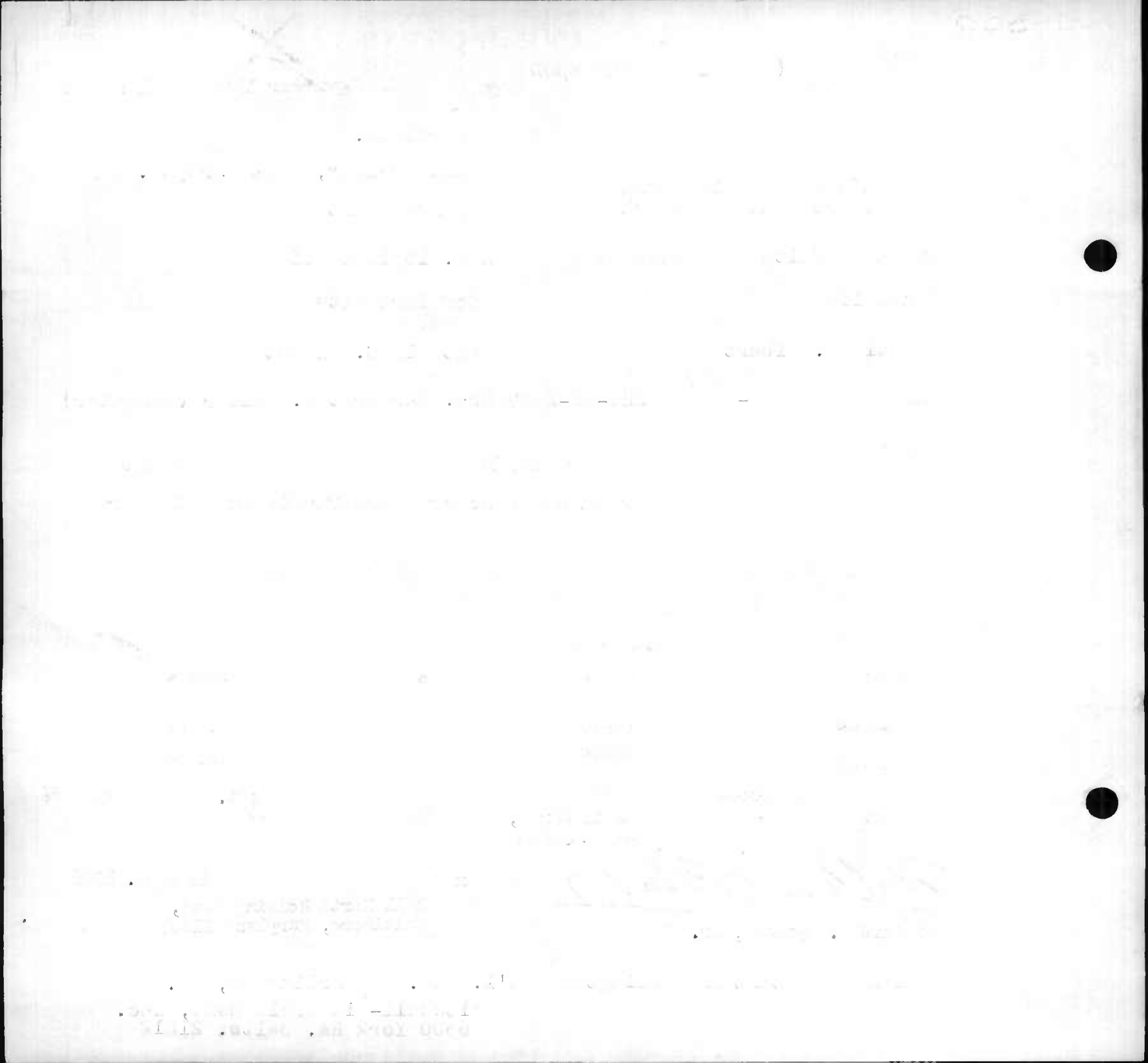
1934

WALTER H. BROWN
RECEIVED
1934

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 66 09304 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09304 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANTONIO | | 2. DATE AND HOUR OF DEATH 10 September 1966 | | 10:10 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nursing Home Liberty Heights & Mohawk | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville, Baltimore Co. D. STREET ADDRESS (If rural, give location) 5 Lyn Court | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Mar. 10 1878 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York City | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Martin E. Albert | | 14. MOTHER'S MAIDEN NAME Antonia E. Albert | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220-48-2689 | | 17. INFORMANT ADDRESS Mrs. Margaret W. Nolley (Daughter) | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Uremia Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION ***** | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED ***** | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ***** | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ***** | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? ***** | |
| 22. I certify that (I) did not attended the deceased from 19 60 to Sept. 19 66 , that (I) was last saw the deceased alive on September 7, 19 66 and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death. | | | | | |
| 23A. SIGNATURE <i>Millard T. Traband, Jr.</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10 Sept. 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. | | 23D. ADDRESS 1811 North Rolling Road, Baltimore, Maryland 21207 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY Arlington Nat'l. Cem. | |
| 24D. LOCATION (City, town, or county) (State) Arlington, Va. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Tolson</i> | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto. 21212 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|------------------|--|--|
| 66 09305 | | CERTIFICATE OF DEATH | | 66 09305 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | KARL SINGEWALD | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 9/10/66 3:10 A.M. | | | |
| The Johns Hopkins Hospt. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| | | Md. Balto 12-06 | | | |
| | | D. STREET ADDRESS (If rural, give location) 17 W. 29th Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Single | 1/26/86 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Attorney | | | | Baltimore | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph T. Singewald | | Magdalena Dreyer | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 219-01-6370 | | Mr. Quentin Singewald (Bro.) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | CARDIAC ARREST | | 3 Wks. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) MYOCARDIAL INFARCTION (C) VILLOUS ADENOMA OF COLON | | 6 Wks. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT 1 1966 to SEPT 10 1966, that (I) last saw the deceased alive on SEPT 10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| A.P. Weinfield | | | | 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| A.P. Weinfield | | Johns Hopkins Hospt. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9/13/66 | | Baltimore Cem | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 16 1966 | | G. B. E. Taylor, M.D. | | Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212 | |

A 22:

204036

Green House

Hydroponic System
only 1/2 inch of water
in 1/2 inch of soil

10/10

10/10

AP 11/11/11

X

10/10

10/10

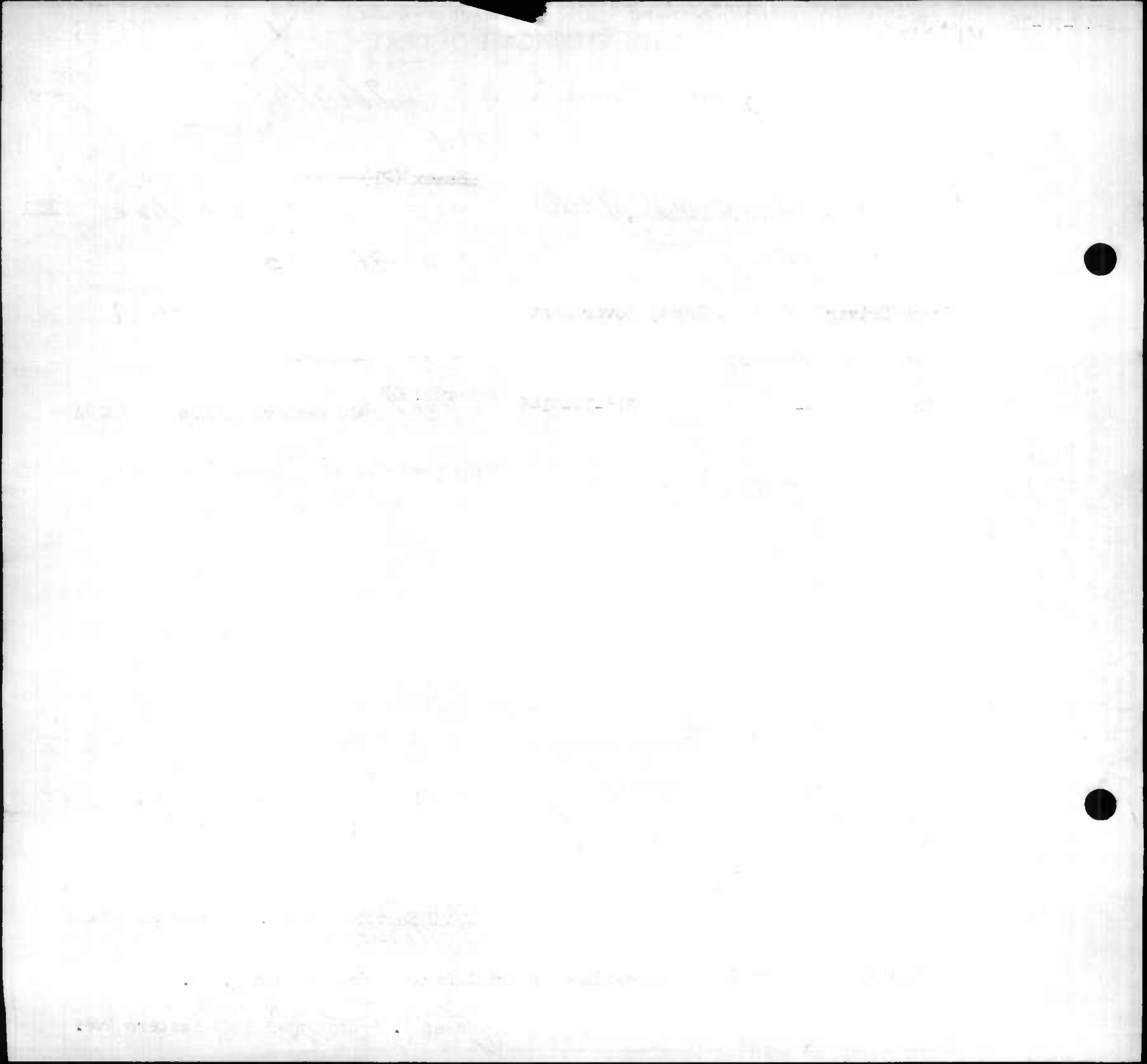
10/10

10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-----------------------------|---|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Moody, Van Brant</i> | | 2. DATE AND HOUR OF DEATH <i>9/13/66 5:00 pm</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hosp. 4940 Eastern Avenue, Baltimore, Maryland</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Essex (21)</i> D. STREET ADDRESS (If rural, give location) <i>815 S. Marlyn Ave 21221</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>9-29-96</i> |
| 9. AGE (In years last birthday) <i>70</i> | | 10. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>County Government</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Harry Moody</i> | | 14. MOTHER'S MAIDEN NAME <i>Ida Swane</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i> | | 16. SOCIAL SECURITY NO. <i>218-14-9146</i> | |
| 17. INFORMANT <i>Records: BCM</i> | | ADDRESS <i>4940 Eastern Avenue 21221</i> | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction 10 yr</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>9/13/66 9:00 am</i> to <i>9/13/66 5:00 pm</i> , that (I) (we) last saw the deceased alive on <i>9/13/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Mary Ann Sullivan</i> | | 23B. DATE SIGNED <i>9/13/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Mary Ann Sullivan</i> | | 23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland Baltimore City Hosp.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>9/17/66</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Memorial Park</i> | 24D. LOCATION (City, town, or county) (State) <i>Howard County, Md.</i> |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 1 1966</i> | | 25B. NAME OF REGISTRAR <i>James E. Brudzinski</i> | |
| 25C. FUNERAL DIRECTOR <i>James E. Brudzinski</i> | | ADDRESS <i>1407 Eastern Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 66 09307 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09307 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) RUSSELL, Walter Ernest | | | September 13, 1966 3:35 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | A. STATE Maryland B. COUNTY Baltimore | | |
| 5. SEX Male 6. RACE Caucasian 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex (21) | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | | D. STREET ADDRESS (If rural, give location) 15 Pelczar Ave. | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Self-employed | | | 8. DATE OF BIRTH 6-3-18 | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 9. AGE (In years last birthday) 48 | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME William Edward Russell | | |
| 14. MOTHER'S MAIDEN NAME Marie Schlotter Williams | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-7-44 to 1-28-46 | | |
| 16. SOCIAL SECURITY NO. 212-16-8794 | | | 17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Md. 21218 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Empyema of left & right pleural spaces - etiology undetermined | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from September 1, 1966 to September 13, 1966 , that (X) (we) last saw the deceased alive on September 13, 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE James S. Louie | | | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) JAMES S. LOUIE | | | | 23D. ADDRESS VA Hospital, Baltimore, Md 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/16/66 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. LOCATION (State) Baltimore, Maryland | | 25A. DATE RECEIVED BY HEALTH DEPT. SEP 16 1966 | |
| 25B. NAME OF REGISTRAR James S. Louie | | 25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home | | 25D. ADDRESS 1407 Eastern Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|--|---|--|---|
| 66-15800 66 09308 | | 66 09308 | | 66 09308 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) PENNINGTON, BABY BOY (John) | | 2. DATE AND HOUR OF DEATH 9-15-66 2:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | A. STATE Maryland B. COUNTY AA | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 4102 Oak Rd | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N. M. | 8. DATE OF BIRTH 7-30-66 | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Clendo Pennington | | | 14. MOTHER'S MAIDEN NAME Mildred Ann Ayce | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 491X1 CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO | | |
| | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemolytic Anemia Hypertirubinemia | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from July 30 1966 to September 15, 1966 , that we (we) last saw the deceased alive on September 15, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE Hector L. Rodriguez | | | | 23B. DATE SIGNED 9-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) HECTOR L. RODRIGUEZ | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/66 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem. | |
| 24D. LOCATION A.A. Co | | 24E. LOCATION Md. | | 24F. LOCATION 237 Patuxent Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR R. E. E. Fairbank | | 25C. FUNERAL DIRECTOR McCully F. H. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------------------------|---|--------------------------------------|--|--|
| 66 09309 | | CERTIFICATE OF DEATH | | 66 09309 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CATHERINE D BROWN | | | |
| 2. DATE AND HOUR OF DEATH 9-13-1966 | | M. 11 A | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1517 W. LEXINGTON ST | | C. CITY OR TOWN (If outside city limits, write R.D. and give township) BALTIMORE | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 1517 W LEXINGTON ST | | | |
| 5. SEX FEMALE | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH July 1892 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) BALTO MD | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward Shipley | | 14. MOTHER'S MAIDEN NAME Kate | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Larry Smith 1516 W Lexington St | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 2, 1966 to September 13, 1966 , that (I) (we) last saw the deceased alive on September 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ralph W. Reckling | | | | 23B. DATE SIGNED 9/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) Ralph W. Reckling M.D. | | | | 23D. ADDRESS 426 N. Gilmore Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9/16/66 | | 24C. NAME OF CEMETERY or CREMATORY MT Auburn | |
| 24D. LOCATION (City, town, or county) (State) BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR SEP 16 1966 | |
| 25C. FUNERAL DIRECTOR Marshall P. Hays | | 25D. ADDRESS 638 N Gilmore St | | | |

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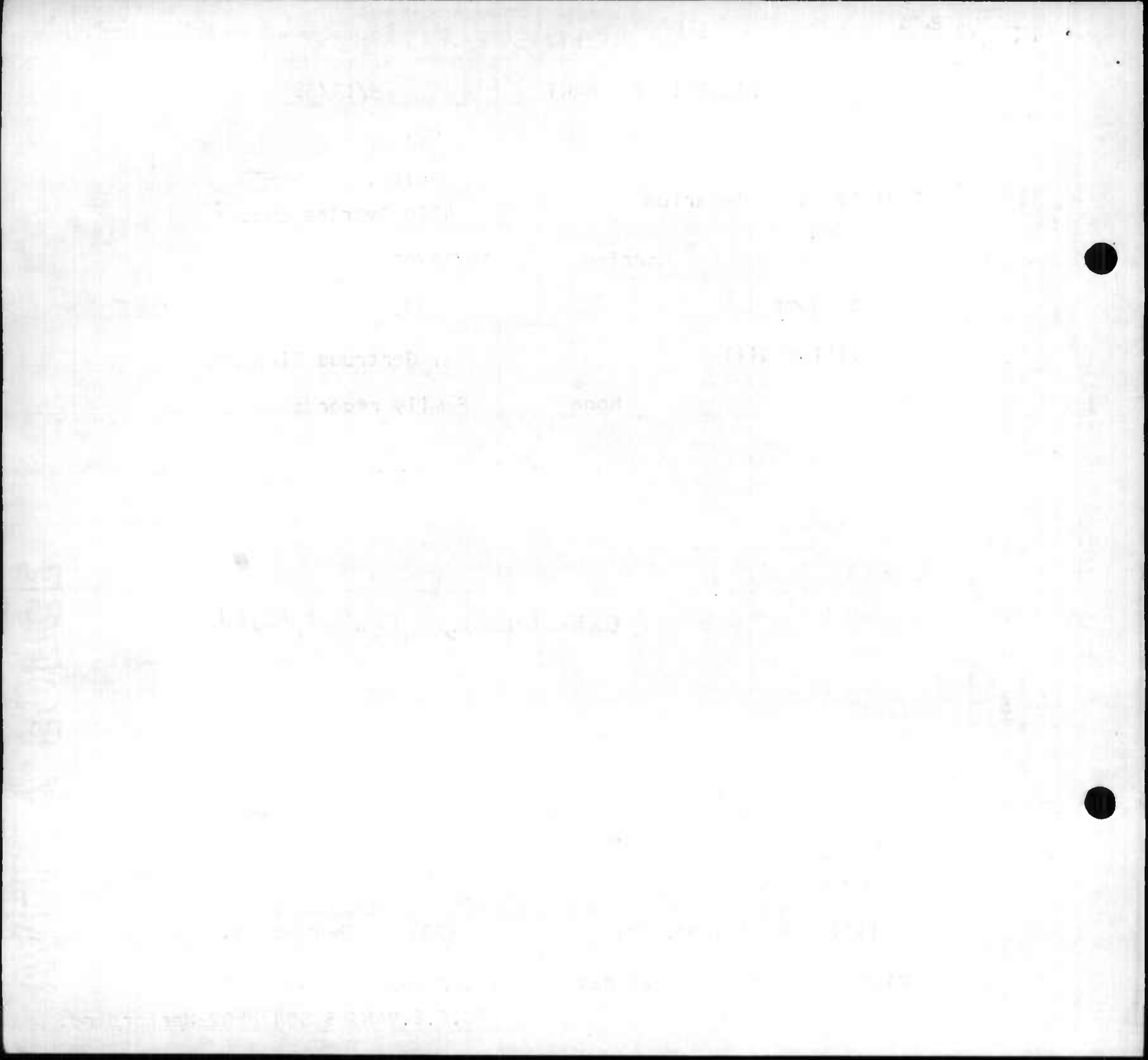
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Barco MD 1/24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--------------|--|---|--|---|--|------------------------------------|--|--|
| 66 09310 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 09310 | | |
| BIRTH NO. 30 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE T HART | | | | | 2. DATE AND HOUR OF DEATH 9/13/66 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould's Convalesarium | | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 4010 Overlea ave. | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 10/10/05 | 9. AGE (In years last birthday) 60 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Gill | | | | | 14. MOTHER'S MAIDEN NAME E. Gertrude Richards | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Family records | | | |
| 18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Due to <u>Lusobaplegia</u> <u>Intracerebral Arterial Thromboses</u> (B) Due to (C) | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arterial Aneurysm, Cerebral, Right</u> | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>9-13</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9-12</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>W.P. Benson, Jr.</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9-14-66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) William P. Benson, Jr. | | | | | 23D. ADDRESS M.D. <u>3506 N. Calvert</u> <u>Charles St.</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/16/66 | | 24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Gardens | | 24D. LOCATION (City, town, or county) (State) Balto Co Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR C.F.E. VANS & SON 8802 Harford rd. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 66 09311 | | BALTIMORE CITY HEALTH DEPARTMENT | | 66 09311 | |
| BIRTH NO. | | M.E. CASE NO. | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) JOHN W. ENGEL | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 14, 1966 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL----DOA | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) ARBUTUS D. STREET ADDRESS (If rural, give location) 5313 HIGHVIEW ROAD, 21227 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 6-14-1891 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKBINDER | | 10B. KIND OF BUSINESS OR INDUSTRY ALBRECHT COMPANY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME WILLIAM ENGEL | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 216-05-1051 | | |
| 17. INFORMANT MR. HAROLD A. ENGEL, 5313 HIGHVIEW ROAD 21227 | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion | | | INTERVAL BETWEEN ONSET AND DEATH Acute | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary insufficiency | | | 10 years | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Angina pectoris | | | 20 years | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1966 to Sept. 1, 1966 , that (I) (we) last saw the deceased alive on Sept. 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gilbert E. Rudman | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/15/66 |
| 23C. PHYSICIAN'S NAME (Type) GILBERT E. RUDMAN | | | 23D. ADDRESS 2517 W. BALTIMORE STREET | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-17-66 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | | |
| 25B. NAME OF REGISTRAR Gilbert E. Rudman | | 25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229 | | | |

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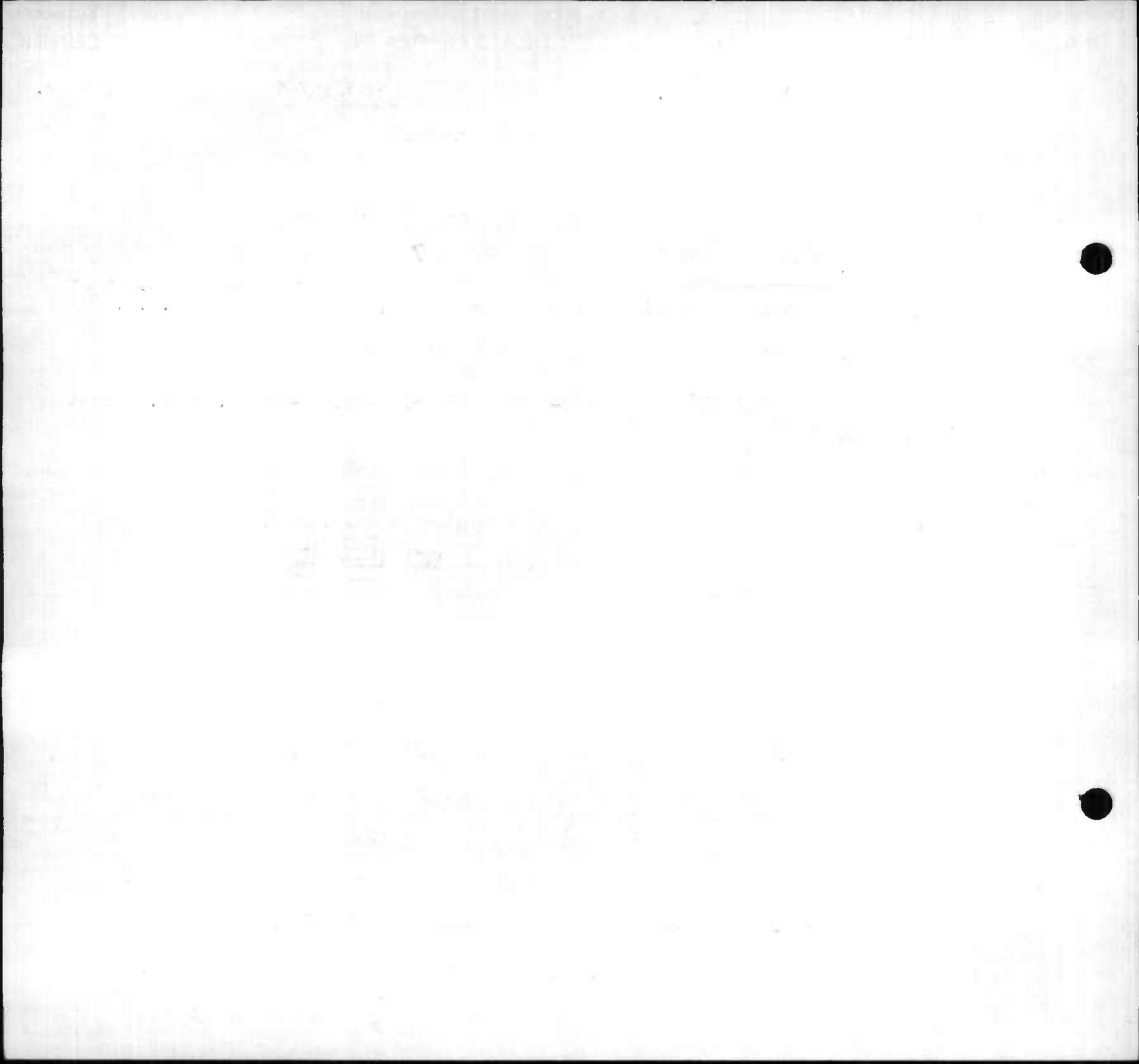
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

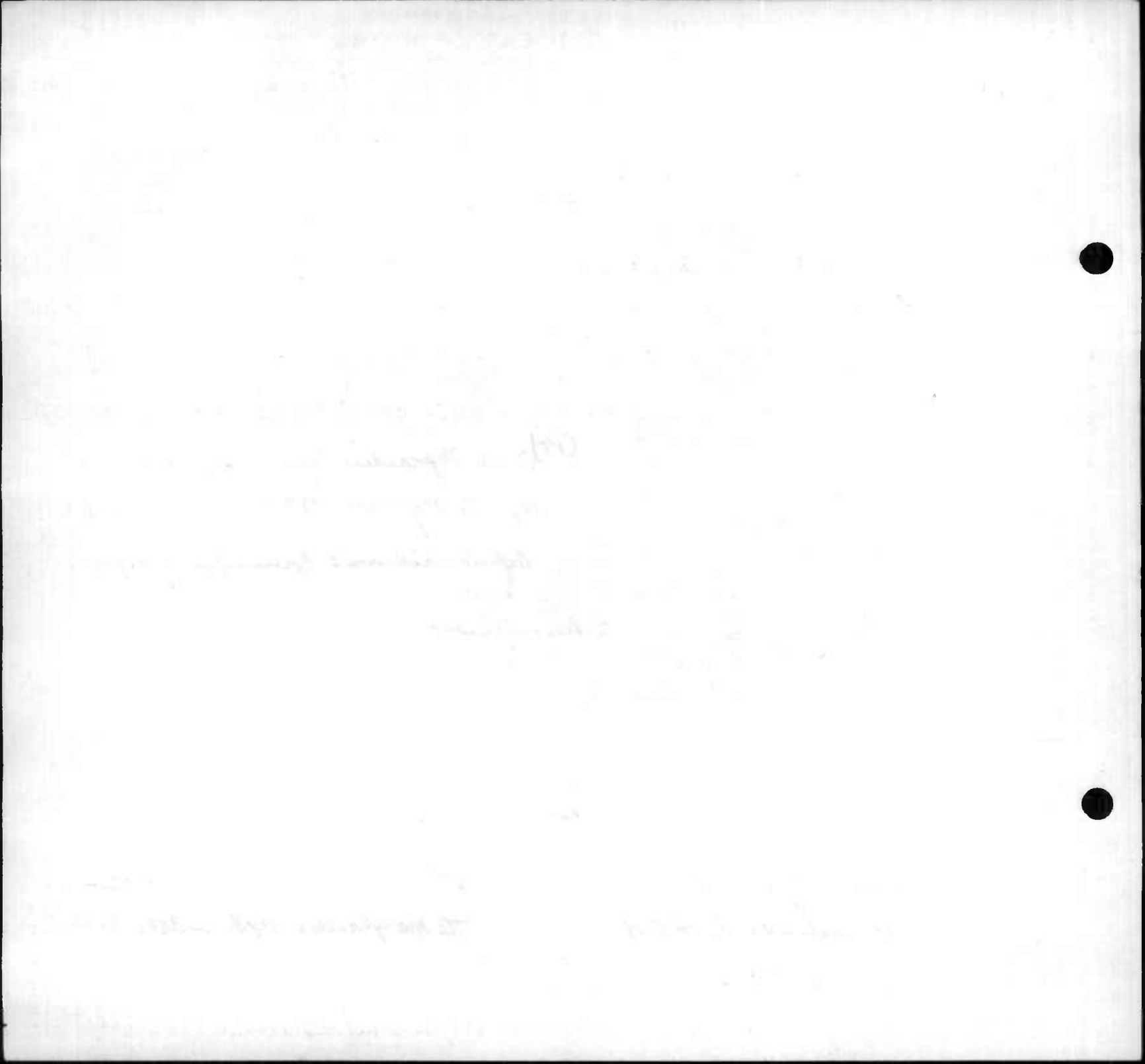
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|--|-------------------------|---|--|--|---|
| BIRTH NO. 66 09312 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09312 | |
| 1. NAME OF DECEASED (Type or Print) Cooper, Raymond E. | | | 2. DATE AND HOUR OF DEATH 9/15/66 6:34 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Keswick Home | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write BURIA and give township) Baltimore D. STREET ADDRESS (If rural, give location) 411 Croydon Road | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Married | 8. DATE OF BIRTH 8/21/87 | 9. AGE (In years lost birthday) 79 years | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking Custodian | | 10B. KIND OF BUSINESS OR INDUSTRY Stadium parking | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Isaac N. Cooper | | | 14. MOTHER'S MAIDEN NAME Clara Cline | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 215-01-4967 | | 17. INFORMANT ADDRESS Keswick Records - 700 W. 40th. Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 30 minutes | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Arteriosclerotic Cardiovascular Disease 5 yrs. | | |
| | | | (C) Rheumatoid Arthritis 22 yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 23 1961 to 15 Sept 1966 , that (I) (we) last saw the deceased alive on 15 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aubrey D. Richardson | | | | 23B. DATE SIGNED 15 Sept 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson | | | | 23D. ADDRESS 700 W. 40th St. Baltimore Md 21211 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) B | | 24B. DATE 9-17-66 | | 24C. NAME OF CEMETERY or CREMATORY Louisa Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR SEP 16 1966 | | 25C. FUNERAL DIRECTOR ADDRESS 411 Croydon Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

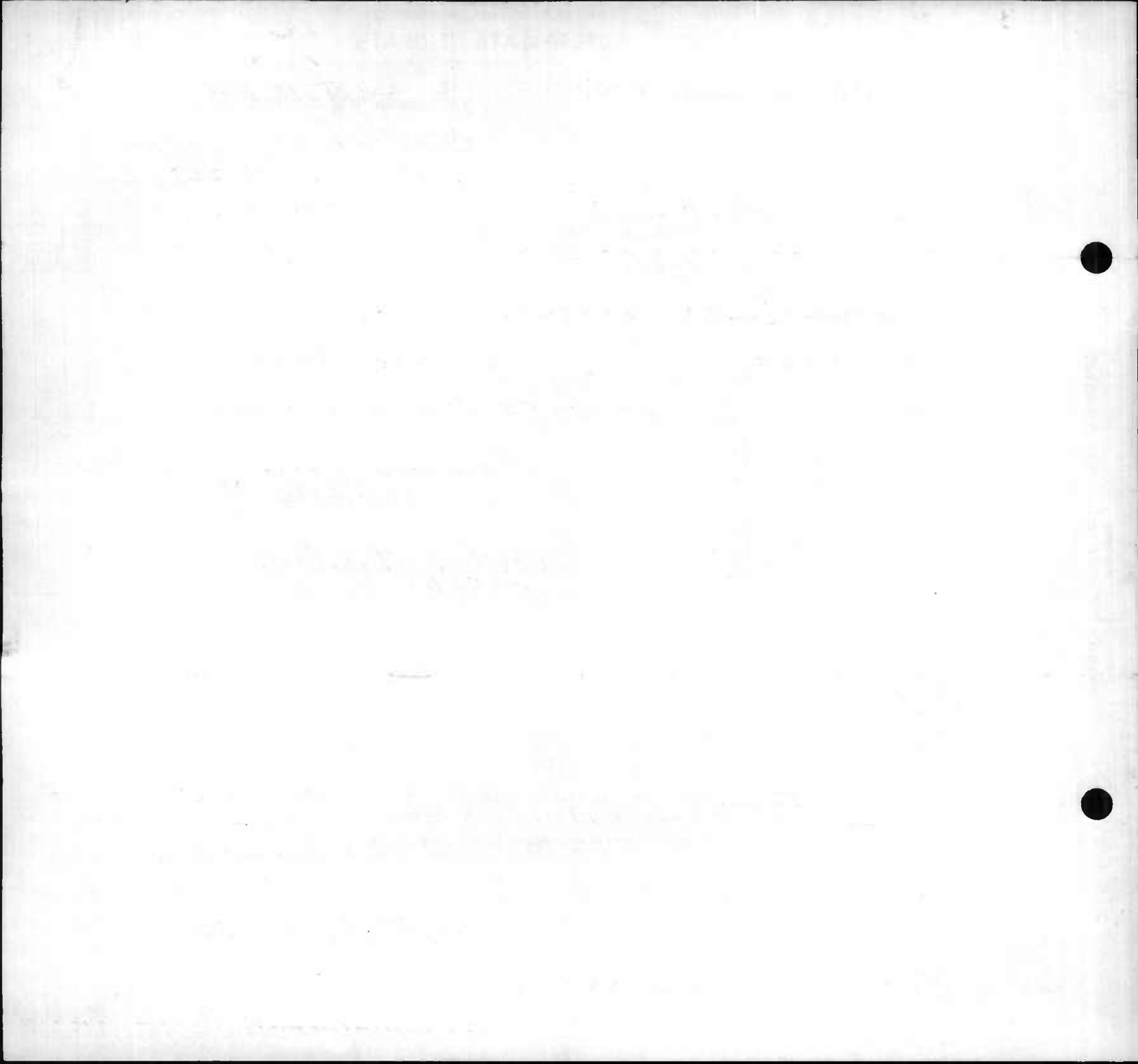
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|--------------------------|--|--|
| 66 09313 | | CERTIFICATE OF DEATH | | 66 09313 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | STEPHEN HYBRZYNSKI | | 9-12-66 6:45 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| | | MARYLAND | | | |
| 90 BELVEDERE NURSING HOME | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 27-17 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2525 W. BELVEDERE AVE. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| MALE | WHITE | WIDOWED | 10-8-1895 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| LABORER | | FISHER BODY | | MARYLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| MICHAEL HYBRZYNSKI | | | ANASTASIA NOWAK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WWI | | 216-10-0282 | | CHRISTIAN SCHOBERLEIN 5921 YORKWOOD RD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (1st) Acute myocardial infarction 8-28-66 | |
| | | (B) DUE TO | | (2nd) Acute myocardial infarction 9-12-66 | |
| | | (C) DUE TO | | Arterio-sclerosis = Coronary = 1-2 years | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| Arterio-sclerosis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1962 to 9-12-66, that (I) (we) last saw the deceased alive on 9-12-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Bernard J. Cohen | | | | 9-12-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Bernard J. COHEN | | The Marylander apt. - 3501 St. Paul St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 9-15-1966 | | ST. STANISLAUS CEMETERY | |
| | | | | BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 16 1966 | | RAYMOND L. KACZOROWSKI | | 2525 FLEET ST. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09314</u> | |
|---|---------------------|--|-----------------------------------|--|--|
| BIRTH NO. <u>66 09314</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>ADA C. HOOD HOOD</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>Sept. 13, 1966</u> <u>11³⁵</u> <u>A</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21228</u> <u>63-00</u> | | | |
| D. STREET ADDRESS (If rural, give location) <u>40 Mellor Ave.</u> | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>1/3/90</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK, DRUG-STORE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Sack Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Loretta Welch</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-05-6454</u> | | 17. INFORMANT <u>Medical Records</u> | |
| 18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO <u>Pneumonia, post Klebsiella</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| (B) DUE TO | | (C) <u>Cerebral thrombosis ASCVD</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 27</u> 19 <u>66</u> to <u>Sept 13</u> 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Sept 12</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Barry N. Rosenbaum</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/13/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARRY N. ROSENBAUM</u> | | 23D. ADDRESS <u>Montebello Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/16/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talley, JR.</u> | | 25C. FUNERAL DIRECTOR <u>E. S. MACNABER</u> | |
| | | | | ADDRESS <u>301 FREDERICK RD BALTO 28</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|-------------------------------------|---|---|
| BIRTH NO. 66 09315 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09315 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>John W. Schoff</u> | | 2. DATE AND HOUR OF DEATH <u>September 13, 1966 3:00 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | D. STREET ADDRESS (If rural, give location) <u>4309 NICHOLAS AVENUE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>04-01-90</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIKEMAN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY FIRE DEPT</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Adam Schoff</u> | | 14. MOTHER'S MAIDEN NAME <u>ELSESSER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-26-9792</u> | | 17. INFORMANT <u>MRS. HOWARD FOLCK (WIFE)</u> | |
| 18. ADDRESS <u>W. W. I.</u> | | 19. ADDRESS <u>SAME</u> | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Branchio pneumonia</u> | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebral arteriosclerosis</u> <u>Pulmonary embolism</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 21, 1966</u> to <u>SEPTEMBER 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 13, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>James W. Carty, Jr., M.D.</u> | | 23B. DATE SIGNED <u>9/13/66</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY, JR.</u> | | 23D. ADDRESS <u>Union Memorial Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/16/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CEMETERY BALTIMORE MD</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Philip E. Fairbank</u> | |
| 25C. FUNERAL DIRECTOR <u>ULLICHT FUNERAL HOME</u> | | 25D. ADDRESS <u>4210 BELAIR</u> | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 09316 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | | 66 09316 | |
|--|--|----------|--|----------------------------------|--|--|--|----------------|--|----------|--|
| M.E. CASE NO. | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Adamson, Stella</i> | | | | | | 9/13/66 1:00 PM 1:00 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hosp. # 21224</i> <i>4940 Eastern Ave. Baltimore, Maryland</i> | | | | | | A. STATE <i>Md</i> B. COUNTY | | | | | |
| 5. SEX <i>Female</i> | | | | | | 6. RACE <i>White</i> | | | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | | | | | | 8. DATE OF BIRTH <i>5-19-08</i> | | | | | |
| 9. AGE (In years last birthday) <i>58</i> | | | | | | 10. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | | | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>Frank MULLINS</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>ALICE MULLINS</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | | | | 16. SOCIAL SECURITY NO. | | | | | |
| 17. INFORMANT <i>Chart</i> | | | | | | ADDRESS <i>DCR RECORDS: 4940 Eastern Ave. Baltimore, Md. # 21224</i> | | | | | |
| 18. CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i> | | | | | | <i>2 days</i> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | <i>Chronic Bronchitis</i> <i>Chronic Bronchiectasis</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | <i>Polyarteritis Nodosa</i> <i>Ulcerative Colitis</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | | |
| 21E. INJURY OCCURRED | | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 21G. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1</i> 19 <i>66</i> to <i>Sept. 12</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept. 12</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Mary Ann Sullivan</i> | | | | | | 23B. DATE SIGNED <i>9/13/66</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Mary Ann Sullivan</i> | | | | | | 23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Maryland # 21224</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | | | 24B. DATE <i>9/16/66</i> | | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i> | | | | | | 24D. LOCATION (City, town, or county) (State) <i>BROOKLYN MD</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1966</i> | | | | | | 25B. NAME OF REGISTRAR <i>Walter E. Taylor, MD</i> | | | | | |
| 25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME</i> | | | | | | ADDRESS <i>DUNDALK MD</i> | | | | | |

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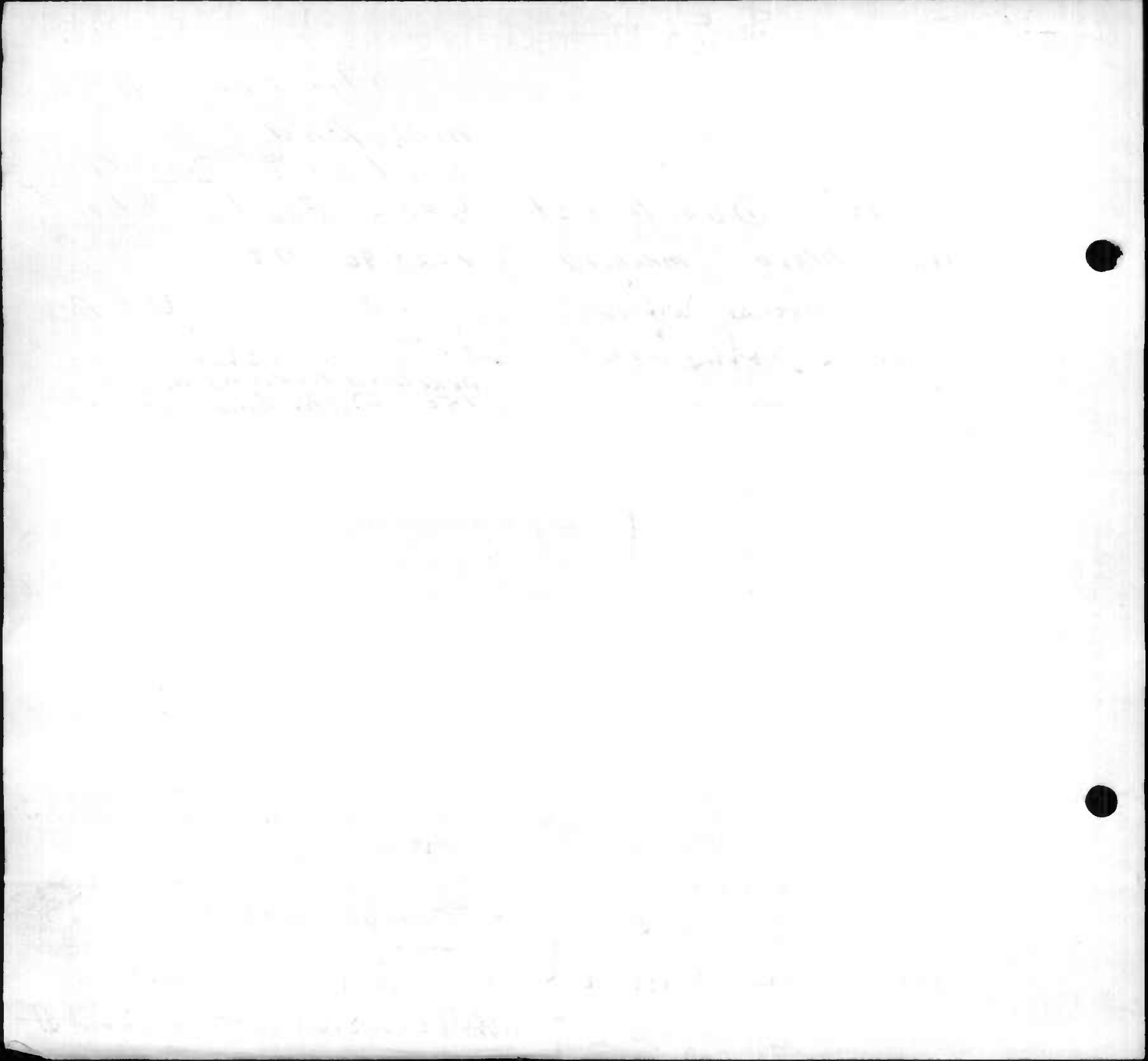
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|--|--|--|
| BIRTH NO. 66 09317 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09317 | |
| 1. NAME OF DECEASED (Type or Print) Lewis, Gertrude | | | 2. DATE AND HOUR OF DEATH 9/14/66 11:15 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Duke Land Nursing Home 1501 Duke Land St. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-09 D. STREET ADDRESS (If rural, give location) 934 S. Baylis Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-23-96 | 9. AGE (In years last birthday) 70 | 10. Under 1 Yr. Months: Days: Hours: Min. 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Julius Johnson | | |
| 14. MOTHER'S MAIDEN NAME Gertrude Johnson | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | |
| 16. SOCIAL SECURITY NO. — | | | 17. INFORMANT ADDRESS Duke Land Nursing Home 1501 Duke Land Street | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) CHRONIC MYOCARDITIS DUE TO (B) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (C) HYPERTENSIVE ENCEPHALOPATHY | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30 1966 to 9-14 1966 that (I) (we) last saw the deceased alive on 9-14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas W. Harris | | | 23B. DATE SIGNED 9-15-66 | | |
| 23C. PHYSICIAN'S NAME (Type) THOMAS W. HARRIS | | | 23D. ADDRESS 1824 W FRANKLIN ST. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 19/66 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery Balto. Md. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 18 1966 | | 25B. NAME OF REGISTRAR Robert E. Williams | |
| 25C. FUNERAL DIRECTOR 1701-3 N Bond St | | 25D. ADDRESS | | | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Klausmeyer, Harold T

2. DATE AND HOUR OF DEATH

11:45 P.M.

9/14/66

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue
Baltimore, Maryland # 212244. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md. Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

520 N. Castle #21205 007

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

9/6/97

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Victor Klausmeyer

14. MOTHER'S MAIDEN NAME

Catherine

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH: Records 4940 Eastern Ave, Baltimore, Md.
21224

ADDRESS

18. 527.21

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Respiratory insufficiency

3 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

lung parenchymal disease
of ? etiology

?

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

ventricular tachycardia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/27 1966 to 9/14 1966,
that (I) (we) last saw the deceased alive on 9/14/66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. P. Wilkinson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/14/66

23C. PHYSICIAN'S
NAME (Type)

C. P. Wilkinson

M.D.

23D. ADDRESS

4940 Eastern Ave, Baltimore, Md.
Baltimore City Hosp # 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS



47-10-34
FR

66 09319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

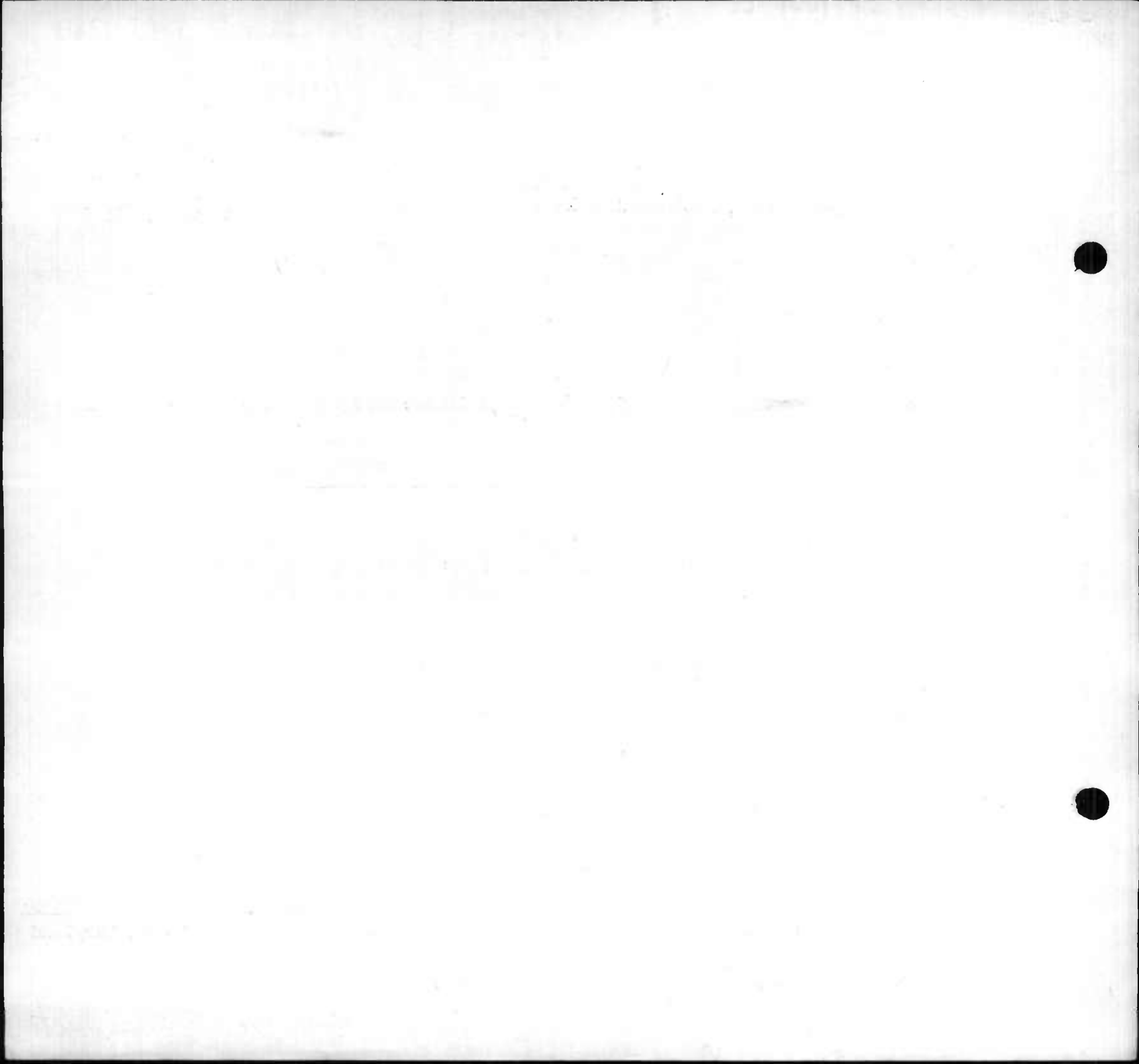
Registered No.

66 09319

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. 66 09319 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09319 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Delia Casey</i> | | 2. DATE AND HOUR OF DEATH <i>9/13/66</i> <i>1230</i> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore City Hospitals 21224</i> <i>4940 Eastern Avenue, Baltimore, Maryland</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i> D. STREET ADDRESS (If rural, give location) <i>223 N. Collington Avenue 21231</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i> | 8. DATE OF BIRTH <i>6/3/75</i> | 9. AGE (in years last birthday) <i>91</i> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ireland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>?</i> | | 13. FATHER'S NAME <i>Daniel Casey</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret Leonard</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-248324</i> | | 17. INFORMANT <i>RECORDS: BCH 4940 Eastern Avenue 21224</i> | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>years</i> | | (A) DUE TO <i>cardiac arrest</i> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>none</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/30</i> 19 <i>66</i> to <i>9/13</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/13</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Bruce M. Dow</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/13/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>BRUCE M. DOW</i> | | 23D. ADDRESS <i>BALTO. CITY HOSPS Baltimore, Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sept 17/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Hill</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Philip M. Herring</i> | |
| 25C. FUNERAL DIRECTOR <i>2024 Adams St</i> | | 25D. ADDRESS | | | |



1
P-620

66 09320

BALTIMORE CITY HEALTH DEPARTMENT

66 09320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

PRICE

2. DATE AND HOUR PRONOUNCED DEAD

September 11, 1966

2:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2113 East North Avenue

33

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-22-34

9. AGE (In years last birthday)

31

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

G.L. MARTIN

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS PRICE

14. MOTHER'S MAIDEN NAME

ORTRA ARRINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-30-4123

17. INFORMANT

MRS. STURDIVANT 721 STIRLING ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Left Chest DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2113 East North Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 9 11 66 12:15

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/11/66

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

9-17-66

23C. NAME of CEMETERY or CREMATORY

ZION HILL

23D. LOCATION

(City, town, or county)

(State)

LITTLETON N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1966

Rudiger Breiteneker

JOSEPH KNIGHT 1639 N. BROADWAY

WALL PAPER

RESIDENT

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09321 | |
|---|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. 66 09321 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Emily R. King</u> | | 2. DATE AND HOUR OF DEATH <u>9-13-66</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Agnes Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY _____ | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>104 S. Kussuth Street</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>8-7-96</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | |
| 13. FATHER'S NAME <u>Watt Best</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>James King 1810 Ashburton St.</u> | |
| 18. <u>4201 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular disease</u> | | CAUSE OF DEATH (A) <u>Cardiovascular disease</u> (B) _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>10-162 to 9-13-66</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-1-1962</u> to <u>9-13-1966</u> and that (I) (we) lost saw the deceased alive on <u>9-13-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John E. T. Camper</u> | | | | 23B. DATE SIGNED <u>9-15-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JOHN E. T. CAMPER</u> | | 23D. ADDRESS <u>639 N. Carey St Balto Maryland</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-13-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1966</u> | | 25B. NAME OF REGISTRAR <u>George G. Nelson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>George G. Nelson 1348 N. Calhoun St.</u> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|---|--|----------------------------------|
| 66 09322 | | CERTIFICATE OF DEATH | | 66 09322 | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| John Satterfield | | | 9-13-66 9:45 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 15-06 | | |
| | | | D. STREET ADDRESS (If rural, give location) 2836 W. North Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | Negro | Married | 11-18-1891 | 74 yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | North Carolina | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Steven Satterfield | | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| | | | 213-03-6114 | | Martha Satterfield (wife) Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | | (A) Massive Pulmonary Embolism | | 10 min. |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Embolism of Left Iliac Vein | | 1-2 days |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Massive Central Embolism, Rt. Malignant Embolism of Left Subcl. & Iliac | | one month 18 months |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 8-8-66 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 30, 1966 to September 13, 1966, that (I) (we) last saw the deceased alive on September 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Roland T. Smoot | | | | 23B. DATE SIGNED 9-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) Roland T. Smoot, | | | | 23D. ADDRESS 3817 Copely Road Balto., Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-17-66 | | Arbutus Mem. Park | |
| | | | | Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 16 1966 | | George G. Kelson | | 1348 N. Calhoun St. | |

11-15-1957
Married
11-15-1957

North Carolina

Martin Oosterlaan (wife)

July 30, 1957
September 13, 1957

3817 Copy to head

1
W-630

66 09323

BALTIMORE CITY HEALTH DEPARTMENT

66 09323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|--|---|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) GLADYS WARD | | | | 2. DATE AND HOUR PRONOUNCED DEAD September 14, 1966 3:00 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2522 Hollins Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 3-3-41 | 9. AGE (In years last birthday) 25 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Luther Ward | | | | |
| 14. MOTHER'S MAIDEN NAME Louise Jones | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. 214-40-6553 | | | 17. INFORMANT ADDRESS Louise Ward 1901 W. Balto. Street | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries. DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Liberty Hgts. Ave., W. of Burleigh St. | | | |
| 21D. TIME OF INJURY (APPROX.) 9 14 '66 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Passenger in auto-bus collision. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D. DATE SIGNED 9/15/66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9-19-66 | | 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 24B. NAME OF REGISTRAR Robert E. Faldut | | 24C. FUNERAL DIRECTOR ADDRESS George G. Kelson 1348 N. Calhoun St. | | | |

WALTER B. BROWN

WALTER B. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09324 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09324 | |
|--|-------------------------|---|-----------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) BIALECKI, MR. ANTONI (ANTHONY WHITE) | | 2. DATE AND HOUR OF DEATH 9/15/1966 11:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 729. S. BROADWAY | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1-7-93 | 9. AGE (In years last birthday) 73 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMECHANIC | | 10B. KIND OF BUSINESS OR INDUSTRY AUTO REPAIRS | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME BIALECKI-STEFA | | | |
| 14. MOTHER'S MAIDEN NAME MARGARET WOJCIECHOWSKI | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 220-05-2815 | | 17. INFORMANT ADDRESS CHURCH HOME & HOSP. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory + cardiac arrest | | 19. CAUSE OF DEATH (A) DUE TO metastatic ca of the brain (B) DUE TO ca of the lung (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____ | | | | | |
| 22. DATE OF OPERATION 0 | | 23. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 24. AUTOPSY? (Yes or No) _____ | |
| 25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 32. HOW DID INJURY OCCUR? | |
| 33. I certify that (I) (this hospital) attended the deceased from Aug. 29 19 66 to Sept. 15 19 66 , that (I) (we) last saw the deceased alive on Sept. 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 34. SIGNATURE Chenith Lury | | 35. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 36. DATE SIGNED 9-15-66 | |
| 37. PHYSICIAN'S NAME (Type) NEVITA SUAREZ | | 38. ADDRESS church Home & Hospital | | | |
| 39. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 40. DATE 9/19/66 | | 41. NAME OF CEMETERY OR CREMATORY HOLY ROSARY | |
| 42. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 43. DATE REC'D BY HEALTH/DEPT. SEP 18 1966 | | | |
| 44. NAME OF REGISTRAR George A. Weber | | 45. FUNERAL DIRECTOR ADDRESS GEORGE A. WEBER - 705 S. ANN ST. | | | |

INTENT

THE NEW YORK

THE NEW YORK

CHURCH HOSPITAL

THE NEW YORK

THE NEW YORK

MD.

AUTOMOBILE

MARGARET

BALANCE

CHURCH HOSPITAL

Respiratory + cardiac

over

ca of the lung
metastasis
ca of the brain

6 months

Sept 12, 1924

Great artery

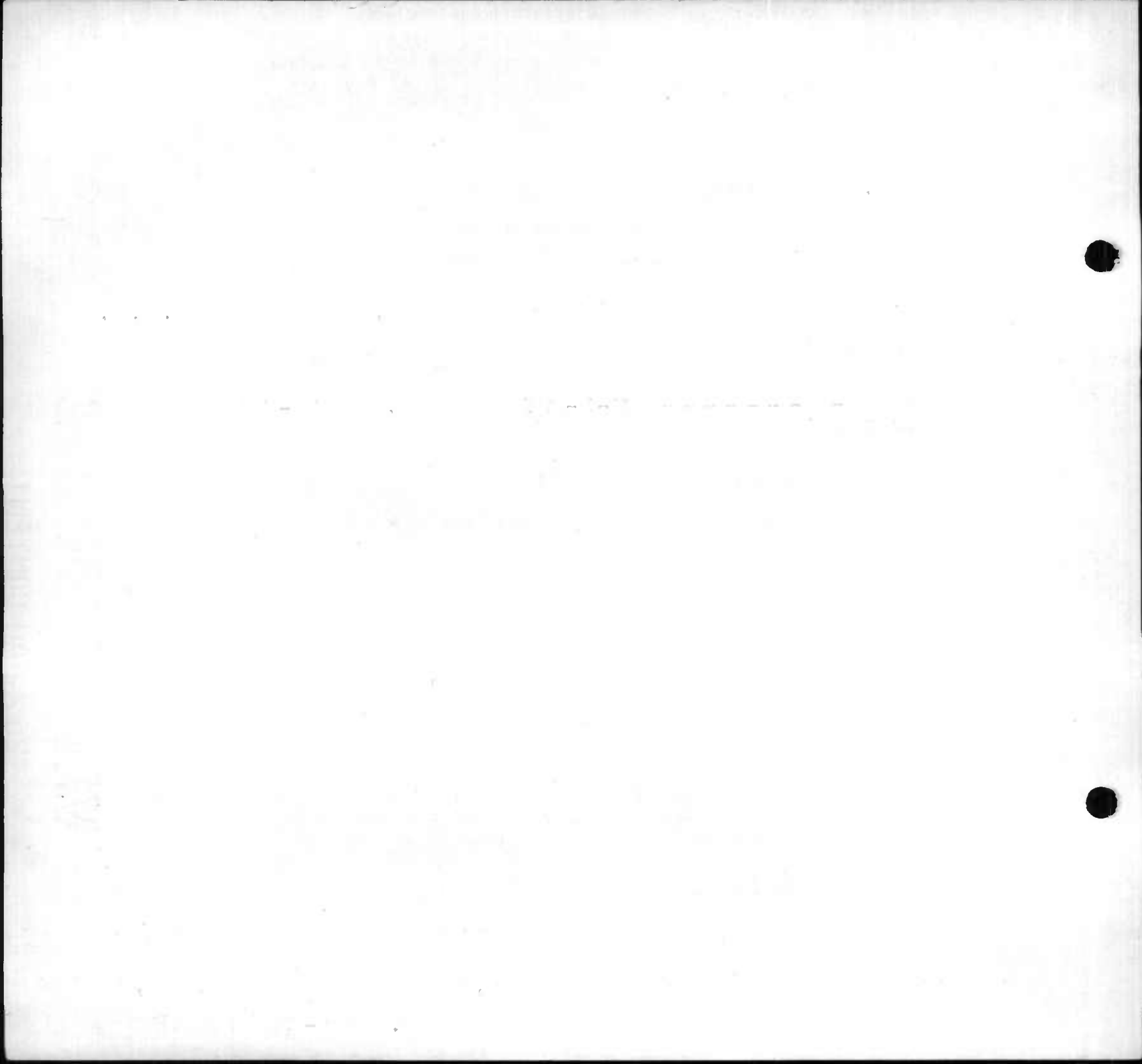
LEFTH

Chamber Heart + Hospital

FUNERAL DIRECTOR: IMPORTANT

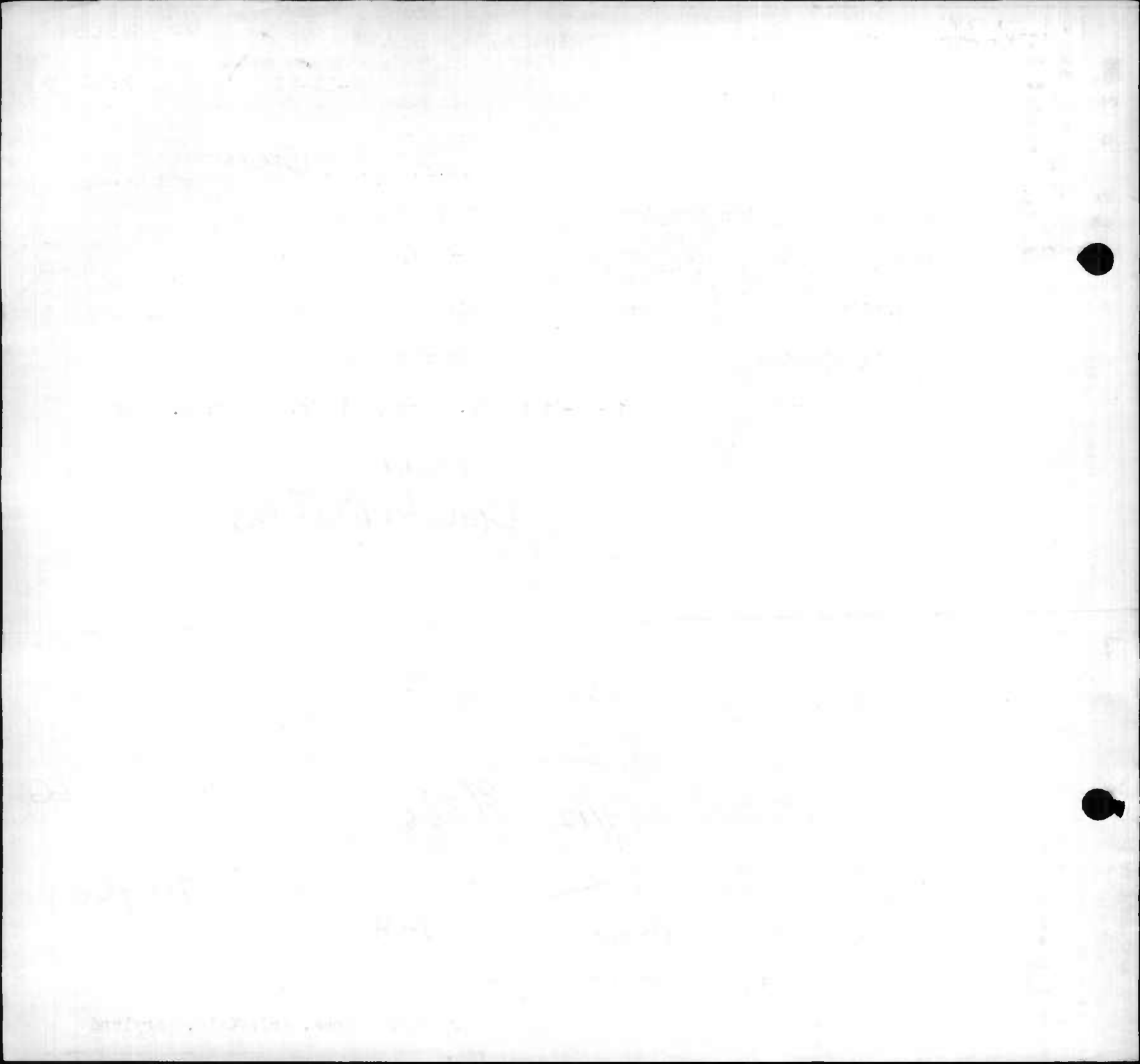
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|--|--|---------------------------------------|--|--|
| P-422 | | 66 09325 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09325 | |
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Palasik, Anthony F. | | 9/15/66 1:55 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital | | | | A. STATE Maryland | | | |
| | | | | B. COUNTY AA | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21225 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 303 5th Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 5/10/05 | 9. AGE (In years last birthday) 61 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10B. KIND OF BUSINESS OR INDUSTRY Hardwood Finisher | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Vincent Palasik | | | | 14. MOTHER'S MAIDEN NAME Mary Duhniewicz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-10-8125 | | 17. INFORMANT Veronica M. Palasik - 303 5th Avenue | | ADDRESS | |
| | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I CAUSE OF DEATH (A) C. V. A. (B) ASCVD (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr 1957 to Sept 15 1966, that (I) (we) last saw the deceased alive on Sept 15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE A.R. Sosnowski | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) A.R. Sosnowski | | | | 23D. ADDRESS 4016 Ritchie Hwy Baltore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/66 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery, Brooklyn | | 24D. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR D. A. J. F. J. J. | | 25C. FUNERAL DIRECTOR George A. Weber - 705 South Ann Street | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|-----------------------------|--|---|
| BIRTH NO. 66 09326 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09326 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Myrtle E. Mister | | 2. DATE AND HOUR OF DEATH 9-12-66 3:15 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 69-39 Crisfield Somerset | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) Locust Street | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 7-25-29 | 9. AGE (In years last birthday) 37 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Crisfield, Maryland | |
| 13. FATHER'S NAME Arlie Riggins | | 14. MOTHER'S MAIDEN NAME Dorothy Lawson | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 218-24-5105 | | 17. INFORMANT ADDRESS Mrs. Dorothy Riggins, Same as 4. ABCD | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia Diabetes Mellitus | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 8/30 1966 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? 9/12 1966 | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30 1966 to 9/12 1966, that (I) (we) lost saw the deceased alive on 9/12 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stan Wilson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) W Stan Wilson | | 23D. ADDRESS JH H. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/15/66 | | 24C. NAME of CEMETERY or CREMATORY Crisfield Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Crisfield, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Bradshaw & Sons, Crisfield, Maryland | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |



CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Marie Griffin

2. DATE AND HOUR OF DEATH

7:00 9/15/66

1.00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

53-00

D. STREET ADDRESS (If rural, give location)

1655 Hopewell Avenue

21221

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

2/28/87

9. AGE (In years
last birthday)

79

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Edwards

Charles Williams

14. MOTHER'S MAIDEN NAME

Annie Harmer

Wanda Williams

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCM-4940 Eastern Avenue

21224

18. 187.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (he) (this hospital) attended the deceased from 9-15-1966 to 9-15-1966,
that (we) last saw the deceased alive on 9-15-1966 and that in (our) opinion death occurred on the date
and hour and from the causes stated above. (We) (did not) view the body after death.

23A. SIGNATURE

Richard L. Bishop

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9-15-66

23C. PHYSICIAN'S
NAME (Type)

Richard L. Bishop

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

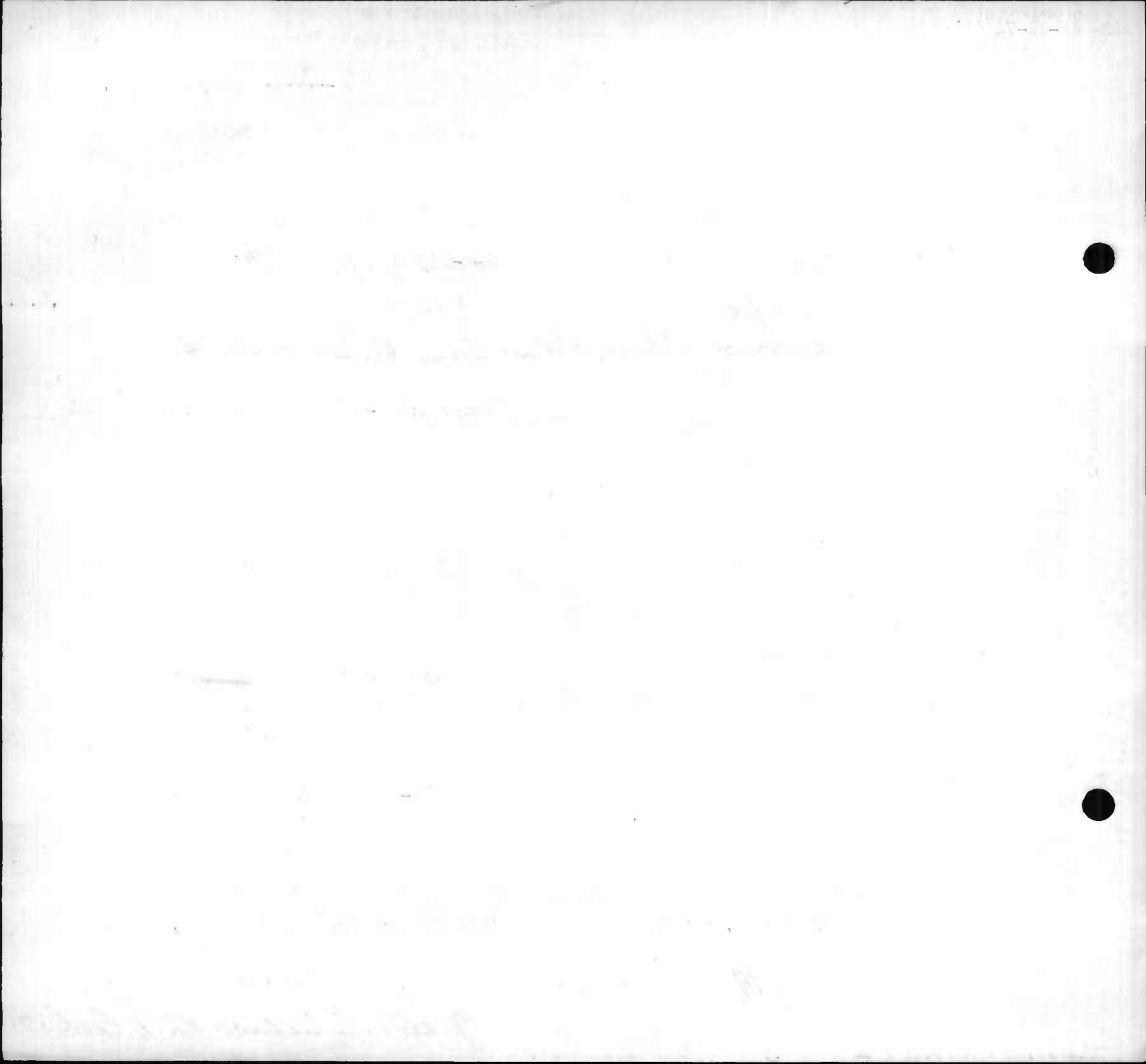
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

23 Edgemoor

6-16-20

Washed

and

the tent

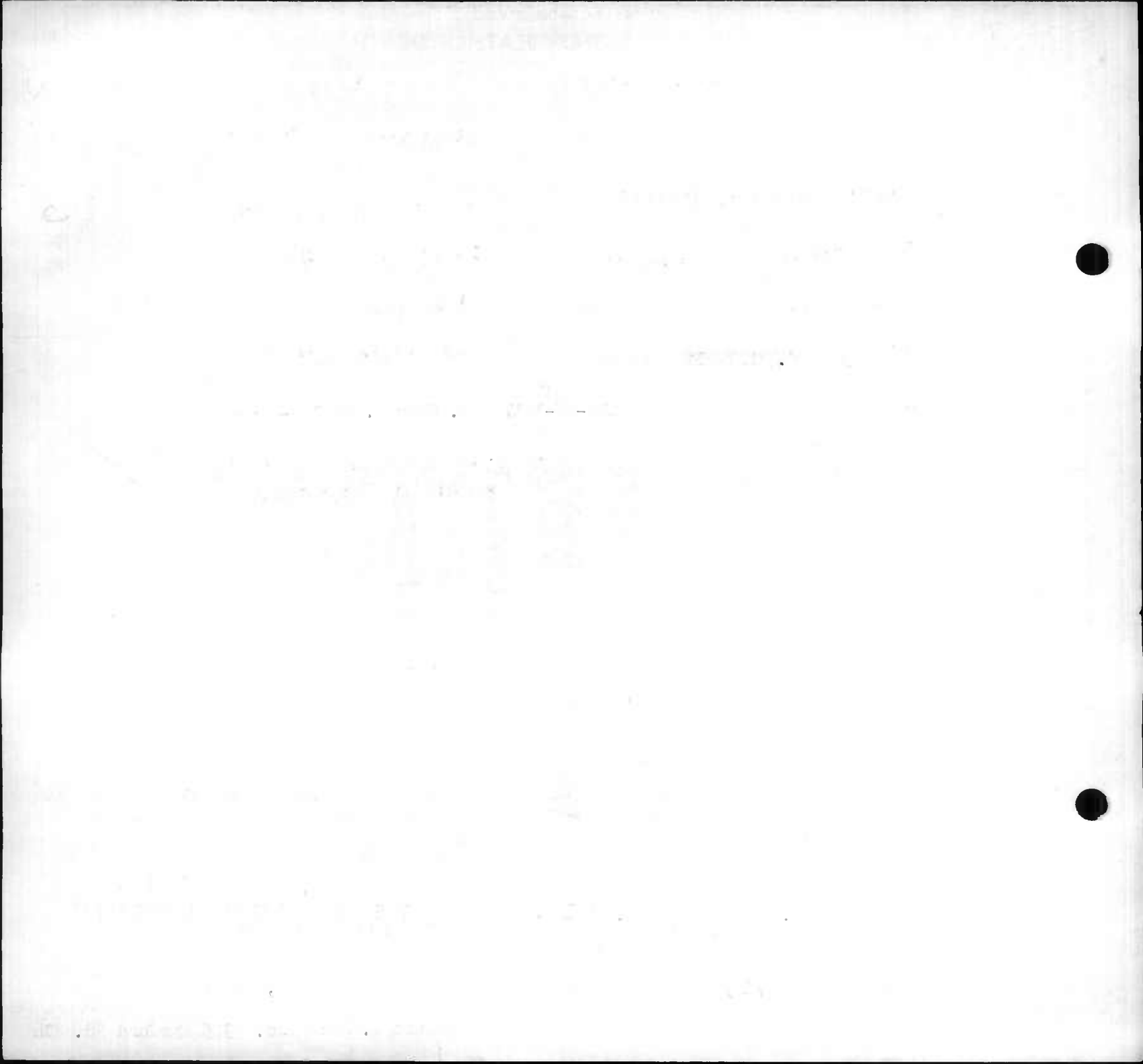
theodore can be seen

High Records

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09329</u> | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. <u>66 09329</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>ROSE SOPHIE KEMLER</u> | | | 2. DATE AND HOUR OF DEATH <u>9-15-66</u> <u>12:00</u> <u>N</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 UNION MEMORIAL HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3025 OAKCREST AVE</u> <u>27-05</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>6-20-89</u> | 9. AGE (In years last birthday) <u>77</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>WILLIAM F. HOBINE Hobine</u> | | | 14. MOTHER'S MAIDEN NAME <u>KATHERINE QUATY</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-18-1917</u> | 17. INFORMANT ADDRESS <u>Mr. John E. Kemler- Same</u> | | |
| 18. <u>332 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBROVASCULAR DISEASE</u> <u>PROBABLY THYROIDOSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> 19 <u>66</u> to <u>9-15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Edilberto G. Gozo</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>9-15-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. EDILBERTO G. GOZO, JR.</u> <u>EDILBERTO G. GOZO, JR.</u> | | | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> <u>UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/19/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>5305 Harford Rd. #14</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 09330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09330

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MELVIE E. PISTORIO

2. DATE AND HOUR OF DEATH

SEPT. 15, 1966 12:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

UNIVERSITY Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MD. BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1724 HULBROOK St. #2

9-09

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-20-05

9. AGE (In years
last birthday)

60

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ADAM R. Barnes

14. MOTHER'S MAIDEN NAME

Nell KOKX ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT Mr. Frank C. Pistorio

ADDRESS

Same as deceased

18.

527.1.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) CHRONIC OBSTRUCTIVE PULM. DISEASE

15

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

NONE

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/13/66 19 to 9/15/66 19
that (I) (we) last saw the deceased alive on 9/15 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael R. Siegel

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

9/15/66

23C. PHYSICIAN'S
NAME (Type)

SAMUEL LEGUM

23D. ADDRESS

M.D.

UNIVERSITY HOSP

BALTIMORE

MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/19/66

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1966

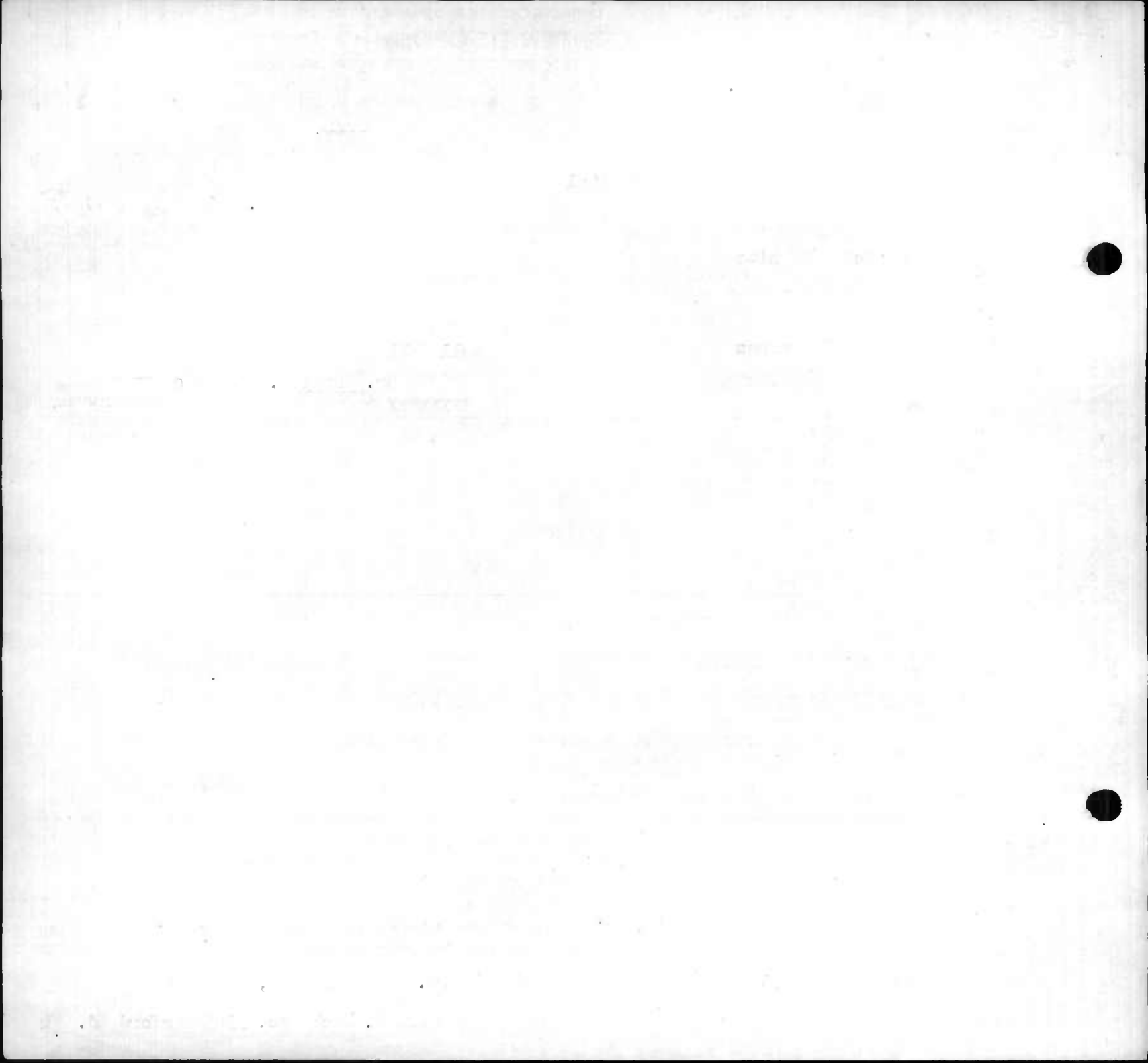
25B. NAME OF REGISTRAR

Leonard J. Ruck Inc.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd. #14

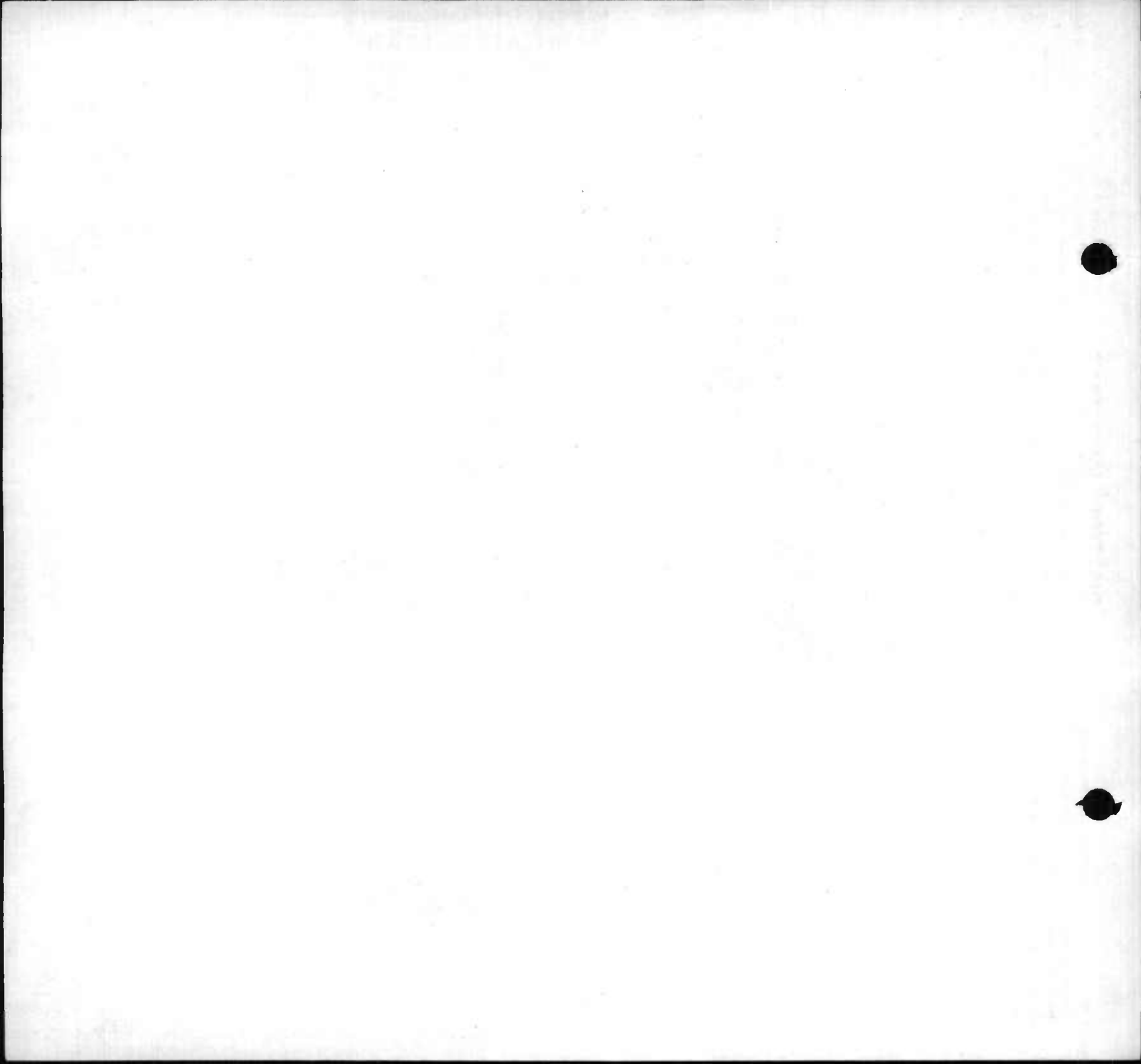
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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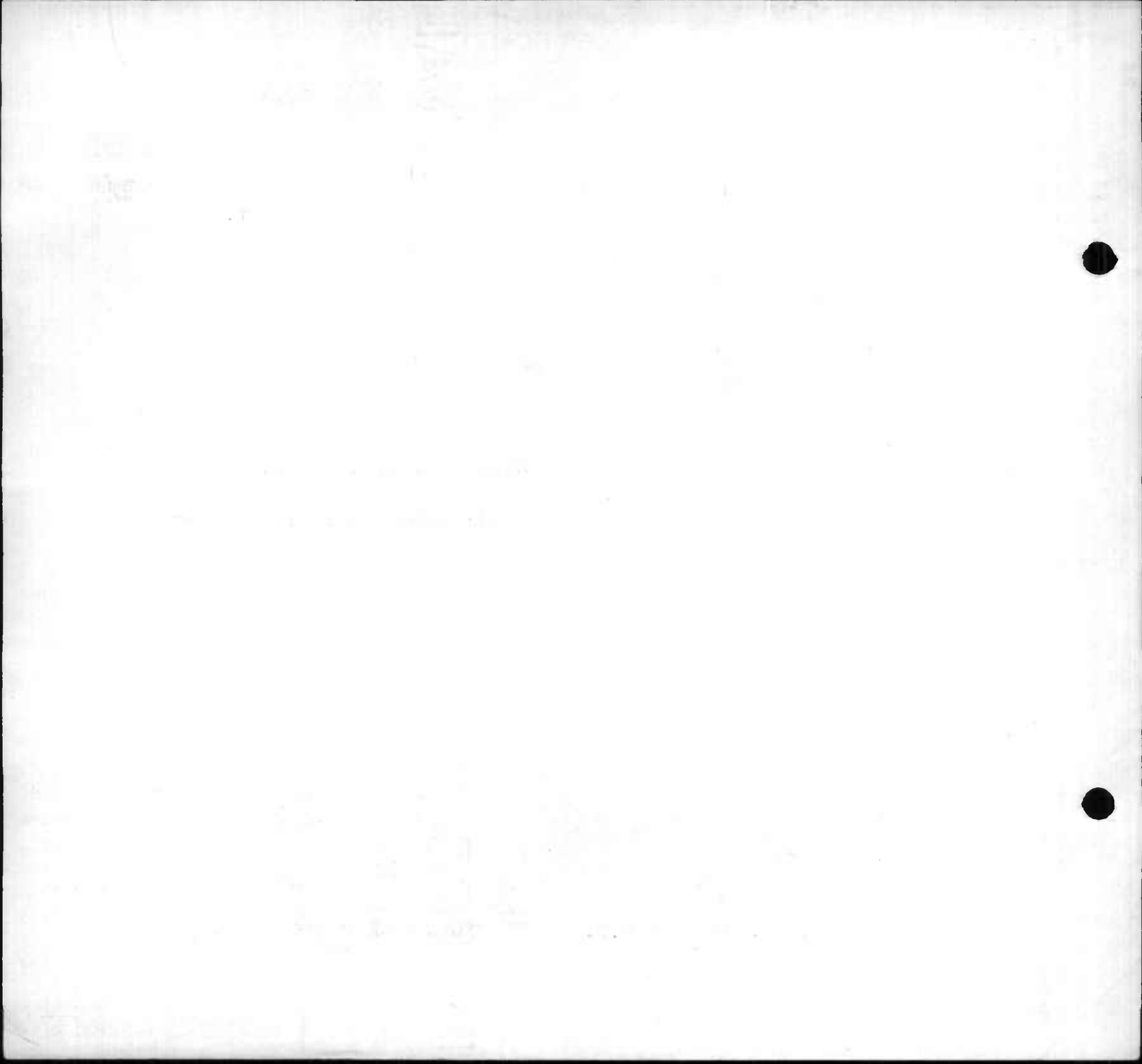
| | | | | | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. <u>64 2197166 09331</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 09331</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Scott, Maurice</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 13, 1966</u> <u>12:30 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hosp. of Baltimore</u> | | A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2427 E. Ttungs St.</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>March 5, 1964</u> | 9. AGE (In years last birthday) <u>2</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | 13. FATHER'S NAME <u>Daniel Scott</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Hammond</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT ADDRESS <u>Hospital Records</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>756.21</u> | | CAUSE OF DEATH (A) <u>cardiac arrest</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Biliary atresia</u> DUE TO | | (C) <u>2 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 13 1966</u> to <u>Sept 13 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 13 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Albert T. Devian</u> M.D. | | 23B. DATE SIGNED <u>Sept. 13, 1966</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. <u>Sinai Hosp. of Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-16</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Brooklyn</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1966</u> | | 25B. NAME OF REGISTRAR <u>Choy Wilson</u> | |
| 25C. FUNERAL DIRECTOR <u>Choy Wilson</u> | | 25D. ADDRESS <u>100 Brantly</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------|--|----------------------------|--|---|
| 66 09332 | | CERTIFICATE OF DEATH | | 66 09332 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Read, Frank | | 9/13-66 10 ¹⁰ P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL. | | MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 7-04 | |
| 33 | | D. STREET ADDRESS (If rural, give location) 1040 Mc DONOUGH ST. 21205 | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 5-6-96 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | | | Baltimore D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME RUFUS Read | | 14. MOTHER'S MAIDEN NAME CARRIE TOLER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-03-6200 | | 17. INFORMANT Cora Read Same | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Carcinoma of lung with DUE TO (B) wide spread metastases DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/12 1966 to 9/13 1966, that (1) (we) last saw the deceased alive on 9/13 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard J. Owellen | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) Richard J. Owellen M.D. | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-18-66 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cent | |
| 24D. LOCATION Brooklyn | | 24E. ADDRESS Mel | | 24F. DATE REC'D BY HEALTH DEPT. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR Cheryl Wilson | |
| 25D. ADDRESS 1000 Briantaylor | | | | | |



P-400

66 09333

BALTIMORE CITY HEALTH DEPARTMENT

66 09333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)CHARLES ~~HORTON~~ POWELL

2. DATE AND HOUR PRONOUNCED DEAD

September 13, 1966 2:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

915 South Sharp Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 South Sharp Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov 13 - 81

9. AGE (In years
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Howard Co. Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Powell

14. MOTHER'S MAIDEN NAME

Julia Pretner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

214-16-8469

17. INFORMANT

Grace Powell

ADDRESS

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422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO

Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-17-66

23C. NAME OF CEMETERY or CREMATORY

Bush River

23D. LOCATION (City, town, or county) (State)

Cat

Howard Co. Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

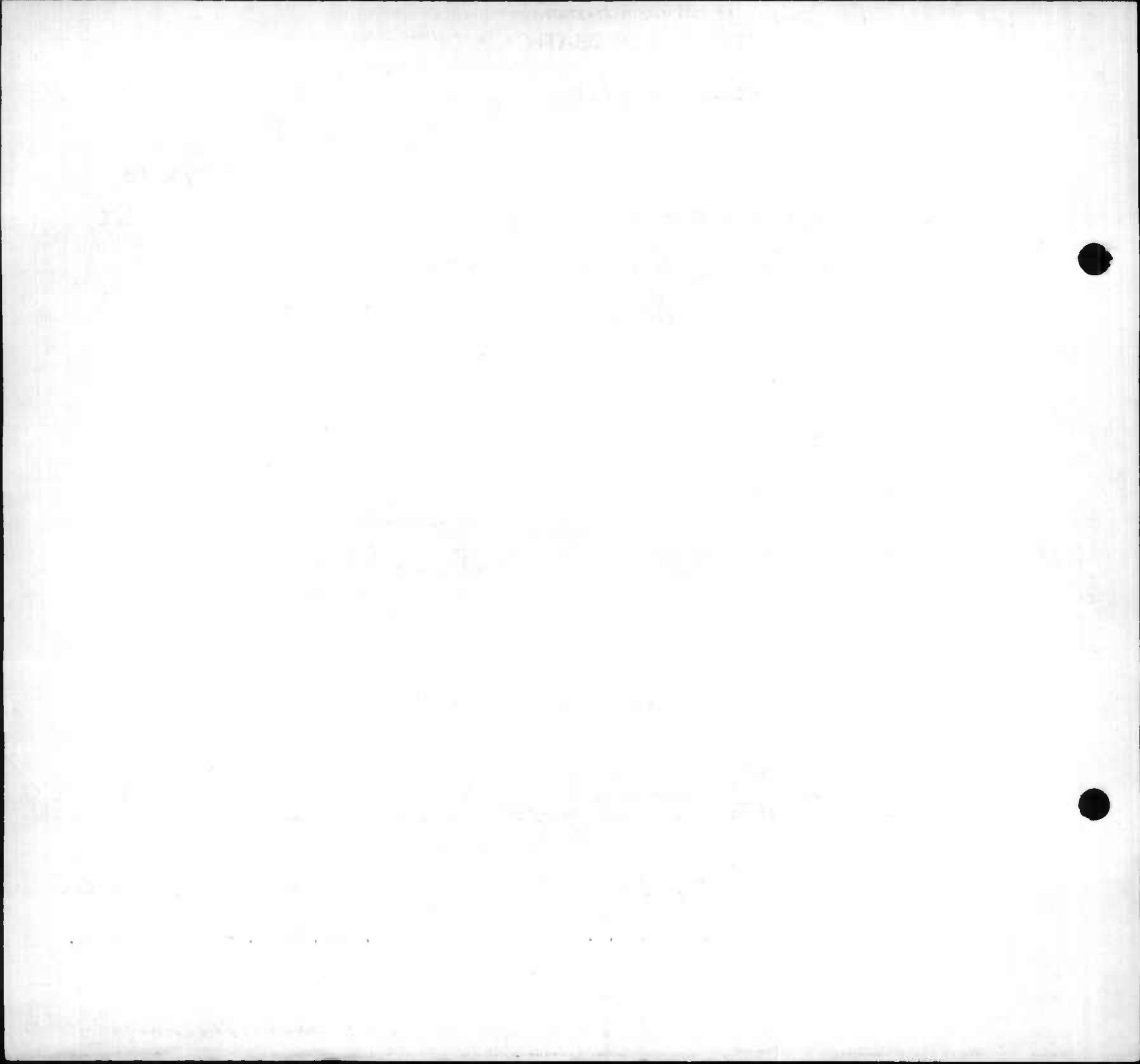
SEP 16 1966

VALLEY FORDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

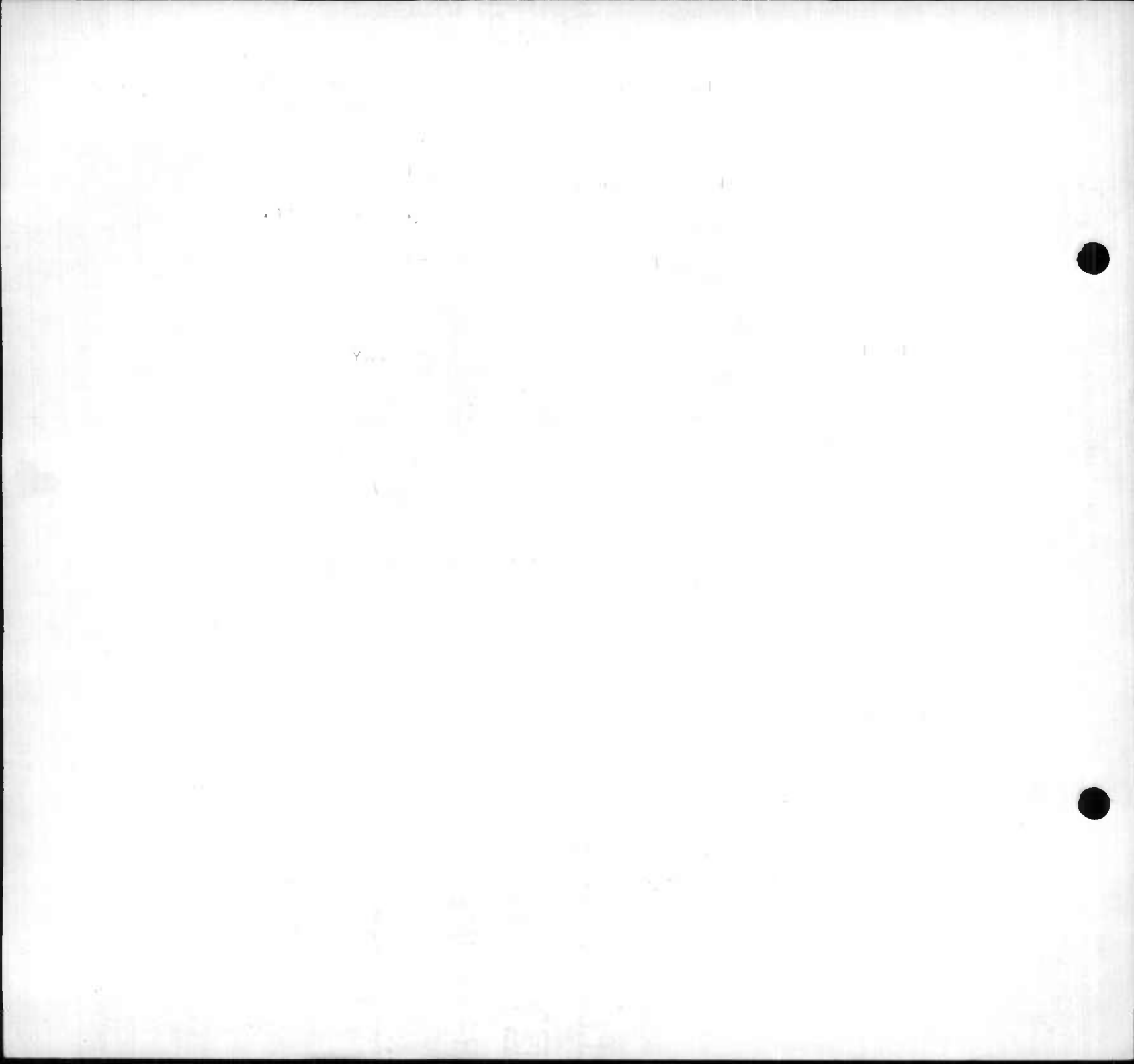
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 09334 | |
|--|-------------------------|---|-------------------------------------|--|--|--|-----------------------|
| BIRTH NO. 66 09334 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Myrtle Taylor | | | | 2. DATE AND HOUR OF DEATH 9-15-1966 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp. | | | | A. STATE Maryland | | B. COUNTY 2201 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 | | | |
| D. STREET ADDRESS (If rural, give location) 709 S. Hanover St. | | | | | | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 10-27-09 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT George Pulley 313 East St. | | ADDRESS | |
| 18. 287 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Pulmonary Embolism DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 29 years | |
| | | | | (B) Uremia DUE TO | | | |
| | | | | (C) Extreme Obesity | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that we (this hospital) attended the deceased from 8-28 1966 to 9-15 1966, that we (we) last saw the deceased alive on 9-15 1966 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Beresford M. Swan | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) BERESFORD M. SWAN, M.D. | | | | 23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-66 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Cheryl Wilson | | 25C. FUNERAL DIRECTOR Cheryl Wilson 1000 Broadway | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09335 | |
|---|----------------------|--|---|--|---|
| BIRTH NO. 66 14862 | | 66 09335 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 66 09335 | | | 1. NAME OF DECEASED (Type or Print) CALVIN BROWN | | |
| 2. DATE AND HOUR OF DEATH 9-14-66 | | | 6:45 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | D. STREET ADDRESS (If rural, give location) 26 S. BETHEL ST. | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) CHILD | 8. DATE OF BIRTH 7-25-66 | 9. AGE (In years last birthday) 1 20 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME WILLIE | | | 14. MOTHER'S MAIDEN NAME DOROTHY SAUNDERS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Calvin Brown ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory Arrest severe dehydration | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malnutrition | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 19 66 to 9/14 19 66 that (I) (we) last saw the deceased alive on 9/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kenneth L Berns M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) KENNETH L BERNES M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-17-66 | | 24C. NAME OF CEMETERY or CREMATORY Not Antone Cal | |
| 24D. LOCATION (City, town, or county) Balto Md | | 24E. (State) 21230 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR Robert S. Johnson | | 25C. FUNERAL DIRECTOR Chas W Wilson - 1000 Brantley Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|---|---|--|
| 66 09336 | | CERTIFICATE OF DEATH | | 66 09336 | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MEZARDASH, HARRY | | | 9-15-66 11:20P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | A. STATE MARYLAND | | |
| | | | B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 1207 LEEDS TERRACE | | |
| 5. SEX MALE | | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-2-1891 | 9. AGE (In years last birthday) 74 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GREECE | |
| 13. FATHER'S NAME GEORGE MEZARDASH | | | 14. MOTHER'S MAIDEN NAME EVELYN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220 01 0988 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cardiogenic Shock</i> (B) <i>Acute Myocardial Infarction</i> (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 2</u> 19 <u>66</u> to <u>SEPTEMBER 15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Ewald Weiss</i> | | | | 23B. DATE SIGNED 9-16-66 | |
| 23C. PHYSICIAN'S NAME (Type) EWALDO WEISS | | | | 23D. ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS AV | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/ 1966 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>E. J. ...</i> | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks, 1217 St. Paul Street Baltimore, Maryland | |
| 25D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | | | | |

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66 09337

BALTIMORE CITY HEALTH DEPARTMENT

66 09337

BIRTH NO. *Balto. Co. Md.* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **BARBARA Ann PEAKS** 2. DATE AND HOUR PRONOUNCED DEAD **September 13, 1966 8:20 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Union Memorial (DOA)** A. STATE **Maryland** B. COUNTY **Baltimore** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **26-02**

D. STREET ADDRESS (If rural, give location) **4802 Minnesota Avenue**

5. SEX **Female** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **single** 8. DATE OF BIRTH **9-6-1966** 9. AGE (In years last birthday) **1 week** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **none** 10B. KIND OF BUSINESS OR INDUSTRY **none** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Robert L. Peaks** 14. MOTHER'S MAIDEN NAME **Janet L. Coleman**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **same** 17. INFORMANT **Robert L. Peaks** ADDRESS **same**

18. CAUSE OF DEATH **Acute bronchopneumonia (SDII)** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Acute bronchopneumonia (SDII)**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **9-15-66** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **same** 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **no** 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) **same** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **same**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **September 14, 1966** ACTUAL SIGNATURE **Charles S. Springate** M.D. ASSISTANT MEDICAL EXAMINER ☒ EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **burial** 23B. DATE **9-15-66** 23C. NAME of CEMETERY or CREMATORY **Moreland Mem. Park** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

24A. DATE REC'D BY HEALTH DEPT. **SEP 16 1966** 24B. NAME OF REGISTRAR **Leonard J. Ruck, Inc** 24C. FUNERAL DIRECTOR **Leonard J. Ruck, Inc** ADDRESS **Baltimore, Md.**

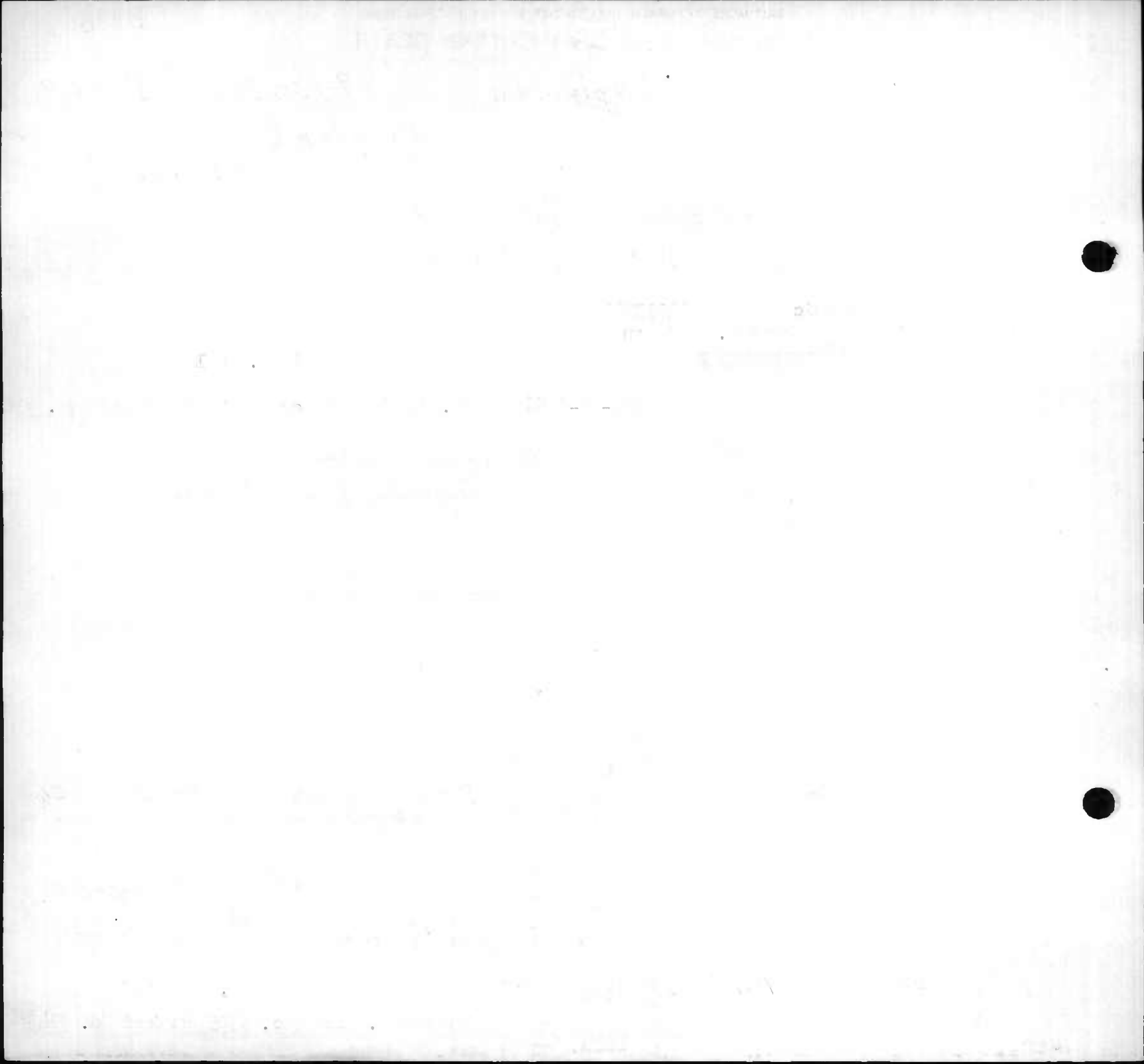
VALLEY BOULDER

ALL CONTENT

414

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|-----------------------------------|---|---|
| BIRTH NO. 66 09338 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09338 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Osborne L. Engleman</i> | | 2. DATE AND HOUR OF DEATH <i>9-13-1966 8:35 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #2123024-01</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i> | | D. STREET ADDRESS (If rural, give location) <i>1371 Andre St.</i> | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 5. SEX <i>M.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>3-9-05</i> | 9. AGE (In years last birthday) <i>61</i> | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Mechanic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Jesse C. Engleman</i> | | 14. MOTHER'S MAIDEN NAME <i>Sophie L. Kahl</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-03-6456</i> | | 17. INFORMANT <i>Mrs. Shirley Barber</i> | |
| 18. <i>321X I</i> | | CAUSE OF DEATH <i>massive pulmonary</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Abnormal function RUL + LUL</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | (B) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (at) (this hospital) attended the deceased from <i>9-10</i> 19 <i>66</i> to <i>9-13</i> 19 <i>66</i> , that (at) (we) last saw the deceased alive on <i>9-13</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Camilo C. Belacuit</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-14-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Camilo C. Belacuit, Jr.</i> | | M.D. 23D. ADDRESS <i>South Balto. General Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/17/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> | | 24E. STATE (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i> | |
| | | | | ADDRESS <i>5305 Harford Rd. #14</i> | |



66 09339

BALTIMORE CITY HEALTH DEPARTMENT

66 09339

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY Ann STURM

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966 10:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5308 Barbara Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5308 Barbara Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4-8-1915

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John E. Bavis

14. MOTHER'S MAIDEN NAME

Barbara Hufnagle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Hubert W. Sturm

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

9-17-66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc Baltimore, Md.

VALLEY FORD

MAINTENANCE

1-2-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|--|---|---|--|
| <p style="font-size: 24pt; margin: 0;">66 09340</p> <p style="font-size: 18pt; margin: 0;">M-6210</p> | | <p style="font-size: 18pt; margin: 0;">CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p> | | <p style="font-size: 18pt; margin: 0;">Registered No. 66 09340</p> | |
| <p>BIRTH NO. 66 09340</p> <p>M.E. CASE NO.</p> | | <p>1. NAME OF DECEASED (Type or Print) Howard MYERS, Sr</p> | | | |
| <p>2. DATE AND HOUR OF DEATH September 14th 1966 3:00 A.M.</p> | | <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> | | | |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>Union Memorial Hospital</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 314 Woodlawn Rd.</p> | | | |
| <p>5. SEX Male</p> | <p>6. RACE White</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed</p> | <p>8. DATE OF BIRTH 10-28-77</p> | <p>9. AGE (In years last birthday) 88</p> | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Known</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY Not Known</p> | | <p>11. BIRTHPLACE (State or foreign country) Maryland</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY? United States</p> | | <p>13. FATHER'S NAME W.H. G.H. MYERS</p> | | | |
| <p>14. MOTHER'S MAIDEN NAME Not Known</p> | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p> | | | |
| <p>16. SOCIAL SECURITY NO. 26-9737</p> | | <p>17. INFORMANT ADDRESS Patients chart</p> | | | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>Pneumonia</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH 48 hrs.</p> | | | |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | |
| <p>19A. DATE OF OPERATION 0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (H) (this hospital) attended the deceased from Sept 13th 1966 to Sept 14th 1966, that (W) (we) last saw the deceased alive on Sept 14th 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE John R. Vaughn, Jr.</p> | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | | <p>23B. DATE SIGNED 9/14/66</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN, JR.,</p> | | <p>23D. ADDRESS THE UNION MEMORIAL HOSPITAL</p> | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 9-16-66</p> | | <p>24C. NAME of CEMETERY or CREMATORY Greenmount</p> | |
| <p>24D. LOCATION (City, town, or county) Baltimore</p> | | <p>(State) Md.</p> | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966</p> | | <p>25B. NAME OF REGISTRAR H.W. Jenkins</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.</p> | |

THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

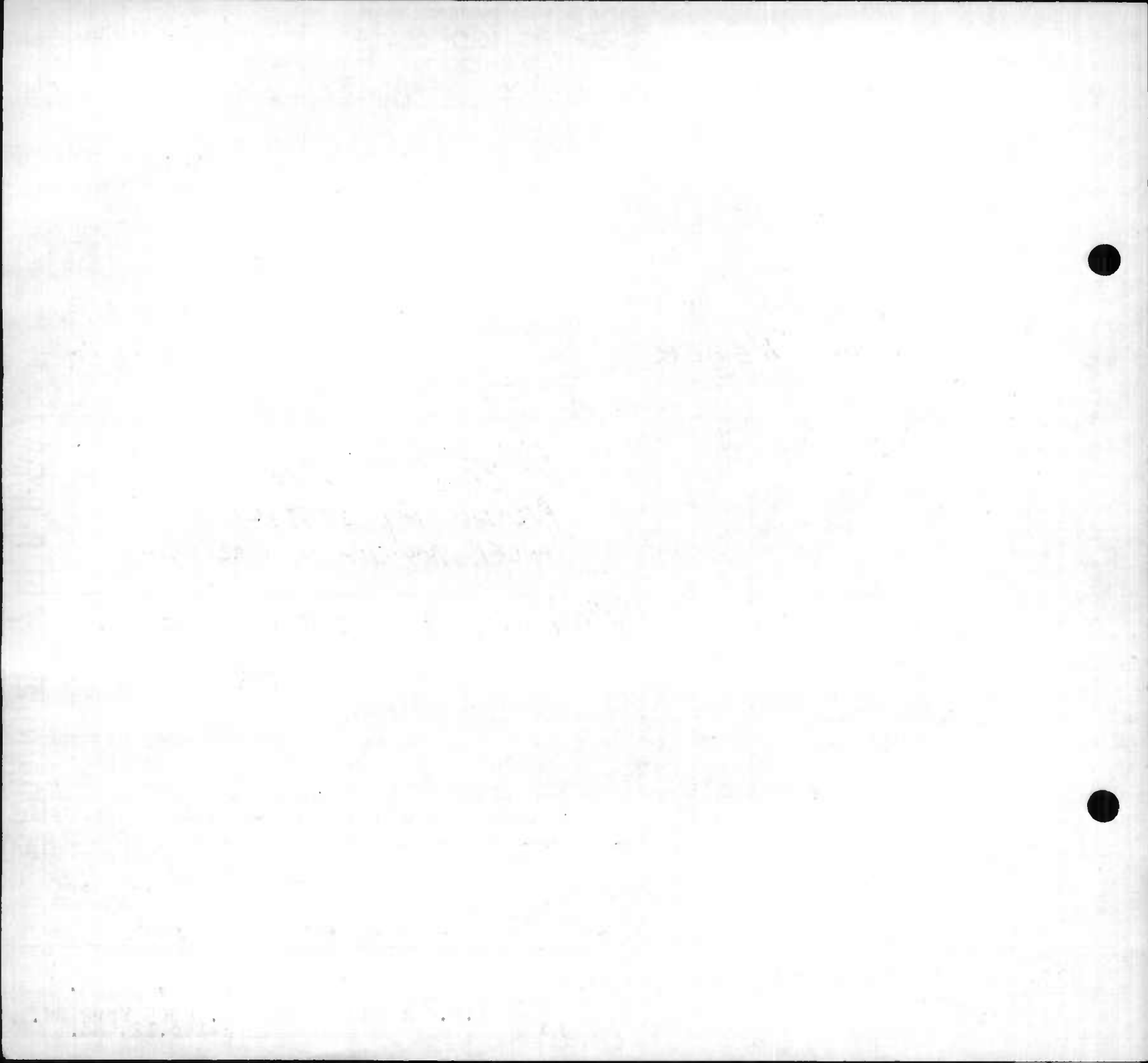
| | | | | | |
|---|-----------|--|--------------------------|--|----------------------------------|
| BIRTH NO. 66 09341 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09341 | |
| M.E. CASE NO. | | SHAW | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) JOYCE F SHAW | | 2. DATE AND HOUR OF DEATH 9/15/66 4:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Fallston, Md. D. STREET ADDRESS Rt. 2 - Friendship Rd. | | | |
| 5. SEX ♀ | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/29/28 | 9. AGE (In years lost birthday) 38 | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - SALES | | 10B. KIND OF BUSINESS OR INDUSTRY Own home - RETAIL | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Walter Hammond | | 14. MOTHER'S MAIDEN NAME Fanny Cassell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 270-24-0944 | | 17. INFORMANT S. Gordon-Records | |
| 18. 600.0 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Anemia | | 5 weeks | |
| ANTECEDENT CAUSES | | (B) Pyelonephritis | | 6 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/9/1966 to 9/15/1966, that (I) (we) last saw the deceased alive on 9/15/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Gordon | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15 | |
| 23C. PHYSICIAN'S NAME (Type) S. Gordon | | 23D. ADDRESS S. N. A. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/1966 | | 24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens | |
| 24D. LOCATION (City, town, or county) Rock Spring Road, Belair, Md. | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co. | | 25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|---|---|---|--|------------------------------------|---|
| 66 09342 | | | | | 66 09342 | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) BERTHA B. Simon | | | | | 2. DATE AND HOUR OF DEATH 9/15/1966 8:10 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GENERAL Hosp. FULL NAME OF (If not in hospital or institution, give street address or location) LINDEN + MADISON AVE BALTIMORE, 2 MD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1203 Found Hill Rd | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | | 8. DATE OF BIRTH 9/19/81 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN WEBER | | | | | 14. MOTHER'S MAIDEN NAME CHRISTIANA VOELKEL | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. 215-48-3479 | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 466X17194.2 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. METASTATIC MALIGNANCY of UNDETERMINED ORIGIN | | | | | CAUSE OF DEATH PULMONARY EMBOLISM PHLEBOTROMBOSIS, ILLAR VENS INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 2 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? — | | | | |
| 22. I certify that (we) (this hospital) attended the deceased from 9/15 1966 to 9/15 1966 , that (we) last saw the deceased alive on 9/15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Louis O. Olsen | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN | | | | | 23D. ADDRESS MD. GEN'L Hosp. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/1966 | | 24C. NAME of CEMETERY or CREMATORY Parkwood | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co. | | | 25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md. | | | | |



66 09343

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09343

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN OWENS

2. DATE AND HOUR PRONOUNCED DEAD

August 19, 1966 12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

404 Aisquith Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

404 Aisquith Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 19, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1966

Robert E. Farber, M.D.

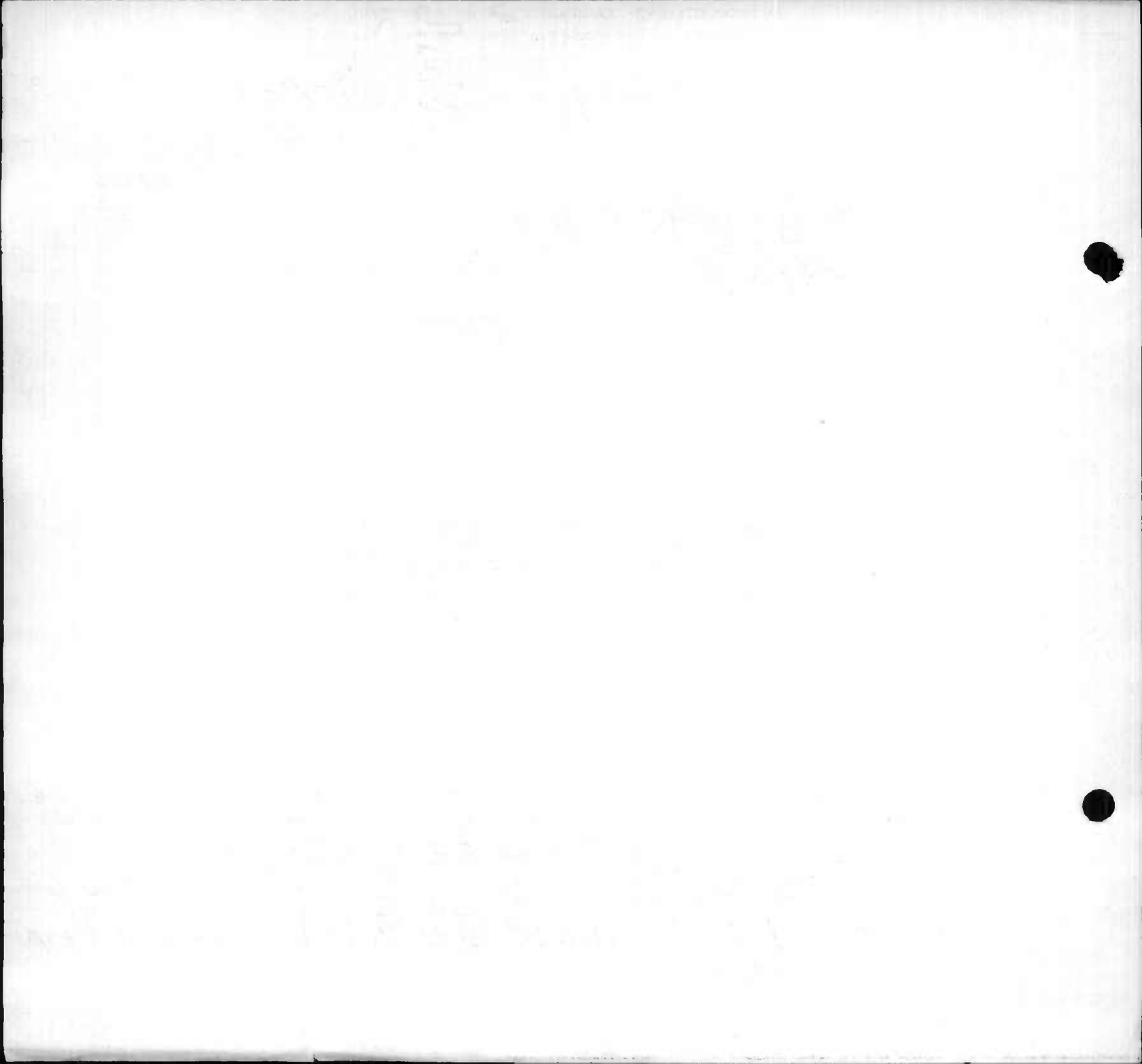
MORTUARY SERVICE - BCHP

6/12/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

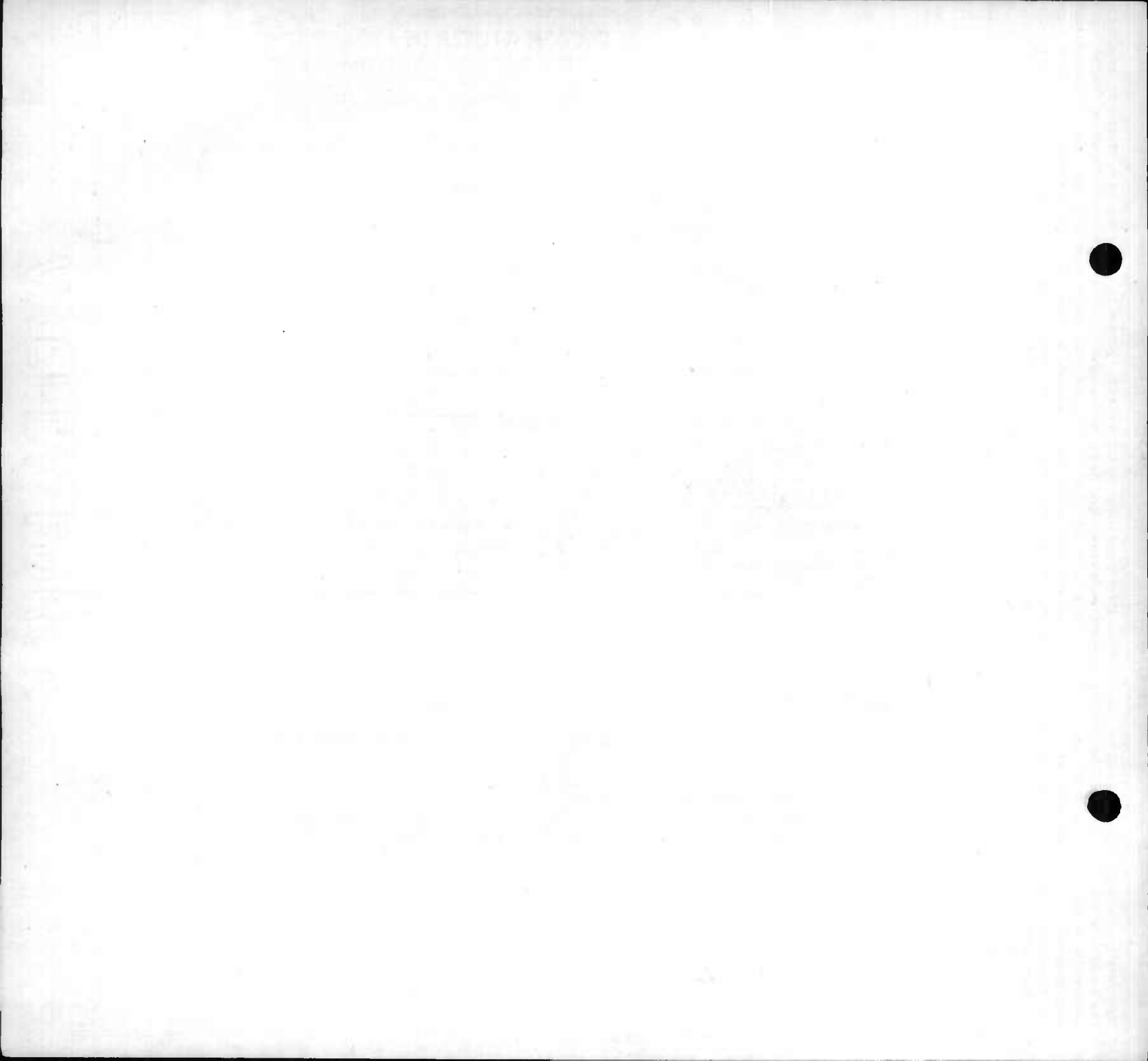
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09344</u> | |
|---|--|--|--|---|--|
| BIRTH NO. <u>66 09344</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Joseph Elzey</u> | | 2. DATE AND HOUR OF DEATH <u>9-11-66</u> <u>3:00 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>22-02</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore # 21230</u> | |
| 5. SEX <u>M.</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| 8. DATE OF BIRTH <u>1-12-1900</u> | | 9. AGE (In years lost birthday) <u>66</u> | | 10. AGE (In years lost birthday) <u>66</u> | |
| 10A. USUAL OCCUPATION (If done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Grasonville, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>561.0 I</u> <u>Malnutrition & Malabsorption</u> <u>Dehydration</u> <u>Pulmonary Abscesses</u> <u>Inguinal Hernia, Incarcerated</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 21. DATE OF OPERATION | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23. AUTOPSY? (Yes or No) <u>YES.</u> | |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner) | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 27. TIME OF INJURY (APPROX.) | | 28. INJURY OCCURRED | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that (this hospital) attended the deceased from <u>9-3</u> 19 <u>66</u> to <u>9-11</u> 19 <u>66</u> , that (we) lost saw the deceased alive on <u>9-11</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 31. SIGNATURE <u>Conso Tador C. Paled, Jr.</u> | | 32. DATE SIGNED <u>9-12-66</u> | |
| 33. PHYSICIAN'S NAME (Type) | | 34. ADDRESS | | | |
| 35. BURIAL CREMATION, REMOVAL (Specify) | | 36. NAME OF CEMETERY or CREMATORY | | 37. LOCATION (City, town, or county) | |
| 38. DATE REC'D BY HEALTH DEPT. | | 39. NAME OF REGISTRAR | | 40. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

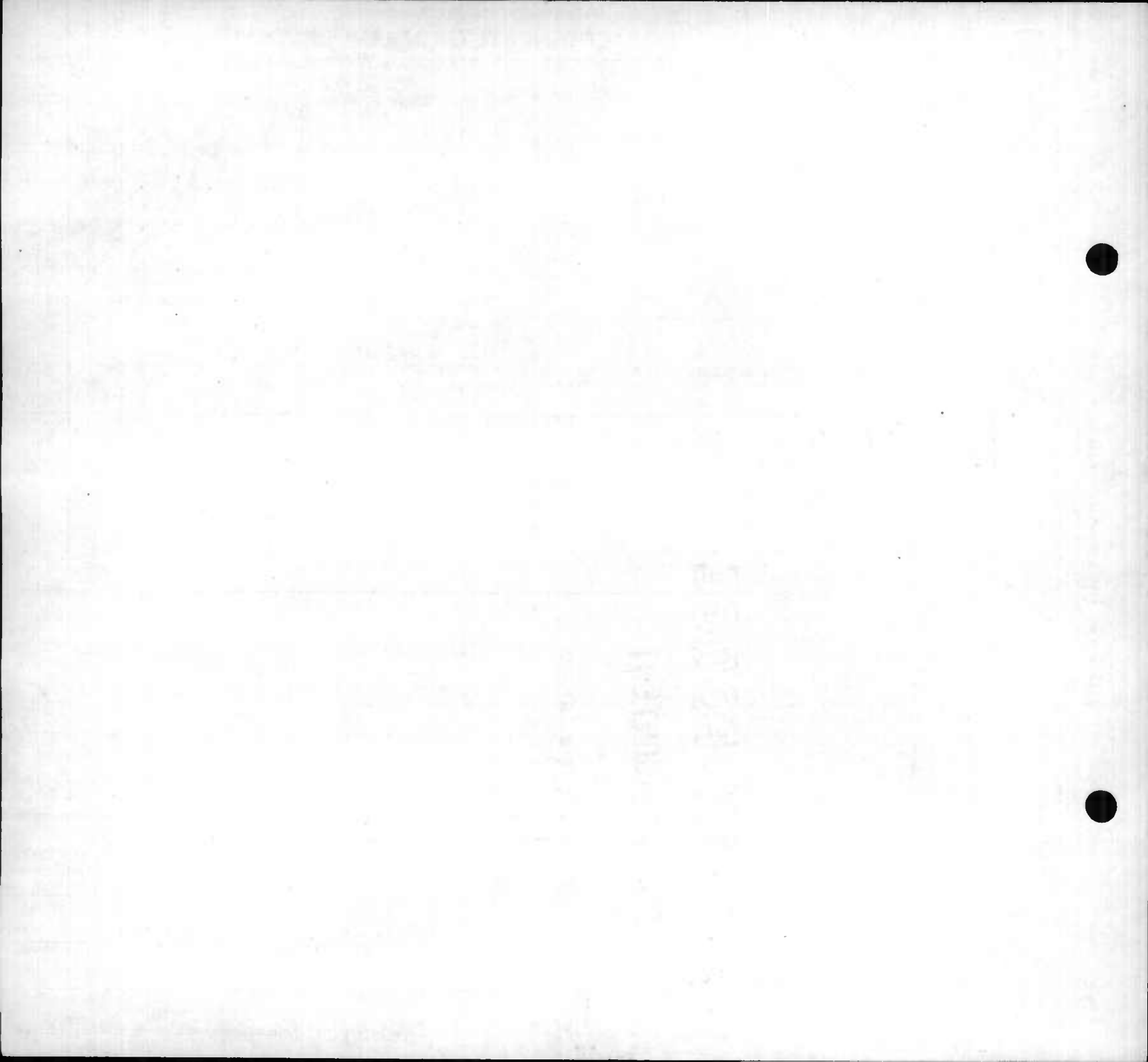
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09345 | |
|---|--------------------------------|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 09345 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KING SOLOMON | | | 2. DATE AND HOUR OF DEATH 8 Sept 66 11²⁰ PM. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO, city MD-18-02 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO - D. STREET ADDRESS (If rural, give location) 1219 WEST FAYETTE ST. | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | 8. DATE OF BIRTH ? | 9. AGE (In years last birthday) 65? | 10. CITIZEN OF WHAT COUNTRY? ? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? | | 10B. KIND OF BUSINESS OR INDUSTRY ? | 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? ? |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? | | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT Chart | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 490 XI | | | CAUSE OF DEATH (A) PULMONARY INSUFFICIENCY DUE TO (B) BILATERAL PNEUMONIA DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 5-7 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHF | | | | | |
| 19A. DATE OF OPERATION 8 SEPT 66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PULMONARY INSUFF | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4 SEPT 19 66 to 8 SEPT 19 66, that (I) (we) last saw the deceased alive on 8 SEPT 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Stanley Music</i> | | | | 23B. DATE SIGNED 8 Sept 66 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9/13/66 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09346 4 | |
|--|-------------------------|--|---------------------------------------|---|---|
| BIRTH NO. 66-18493 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Jones, Baby Girl</i> | | 2. DATE AND HOUR OF DEATH <i>8-26-66 11:05 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>17-01</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>900 Angyle Ave</i> | | | |
| 5. SEX <i>♀</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i> | 8. DATE OF BIRTH <i>8-26-66</i> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i> | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <i>Balto md</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>?</i> | | 14. MOTHER'S MAIDEN NAME <i>Phyllis Jones</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT <i>Chast</i> ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>776X I</i> | | CAUSE OF DEATH (A) <i>Immaturity</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>Like</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that <i>he</i> (this hospital) attended the deceased from <i>1:50 pm</i> <i>8-26-1966</i> to <i>11:05 pm</i> <i>8-26-1966</i> , that <i>he</i> (we) last saw the deceased alive on <i>8-26-66</i> 19 and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Edward J. Ruley, M.D.</i> | | | | 23B. DATE SIGNED <i>8-26-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Edward J. Ruley</i> | | | | 23D. ADDRESS <i>ANA University Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>9/13/66</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i> | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>SEP 16 1966</i> | | 25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i> | |
| 25D. ADDRESS | | | | | |



1
S-530

66 09347

BALTIMORE CITY HEALTH DEPARTMENT

66 09347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Rebecca Smith

2. DATE AND HOUR PRONOUNCED DEAD

9/6/66 4:40 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1308 Bruce St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1301 Bruce St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday) 43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic and hypertensive cardio-
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9/15/66

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1966

Robert E. Taylor, M.D.

MORTUARY SERVICE - BCHD

WALLACE DOUGLAS

REAR CONTINENT

11/15/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

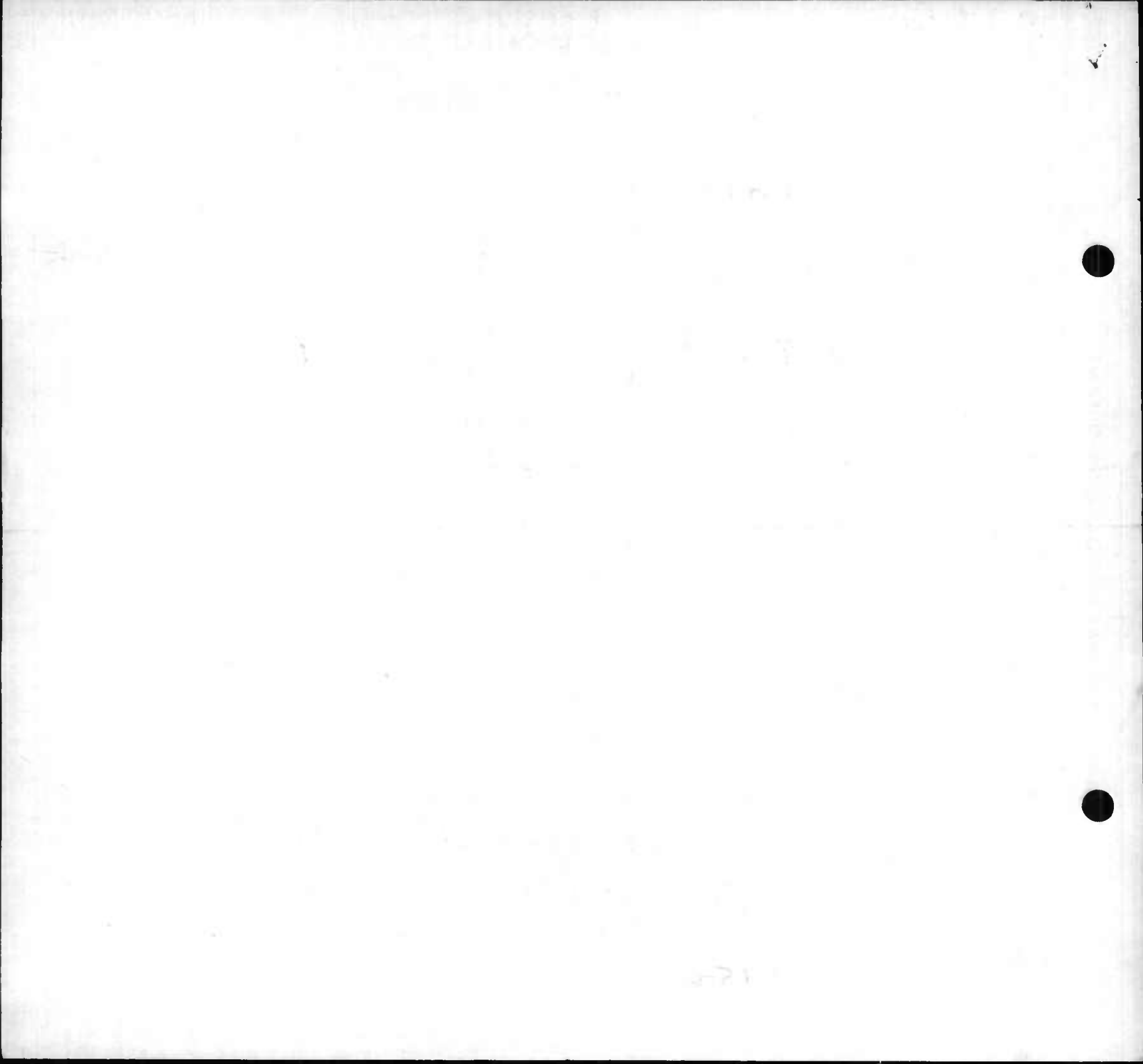
| | | | | | |
|--|--------------|--|----------------------------|--|--|
| BIRTH NO. 66-19118 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09348 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY GLASS | | 2. DATE AND HOUR OF DEATH 9/7/66 944 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 12-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAL HOSPITAL OF BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) 42 406 E. 24th ST. | | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MM. | 8. DATE OF BIRTH 9/7/66 | 9. AGE (In years last birthday) 14 HRS. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 14 20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME ROVESTER GLASS | | | |
| 14. MOTHER'S MAIDEN NAME BARBARA HUNTER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS (HOSPITAL CHART) - | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 762.01 PRIMARY APNEA | | INTERVAL BETWEEN ONSET AND DEATH 14 HR. 20 MIN | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/7 (7:24 AM) 19 66 to 9/7 (944 PM) 19 66, that (I) (we) last saw the deceased alive on 9:20 AM 9/7/19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheldon M. Frank | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/7/66 | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON M. FRANK | | 23D. ADDRESS SINAL HOSPITAL OF BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 9-15-66 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND | |
| 24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL | | 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | | |
| 25B. NAME OF REGISTRAR J. J. J. J. | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | | |



FUNERAL DIRECTOR: IMPORTANT

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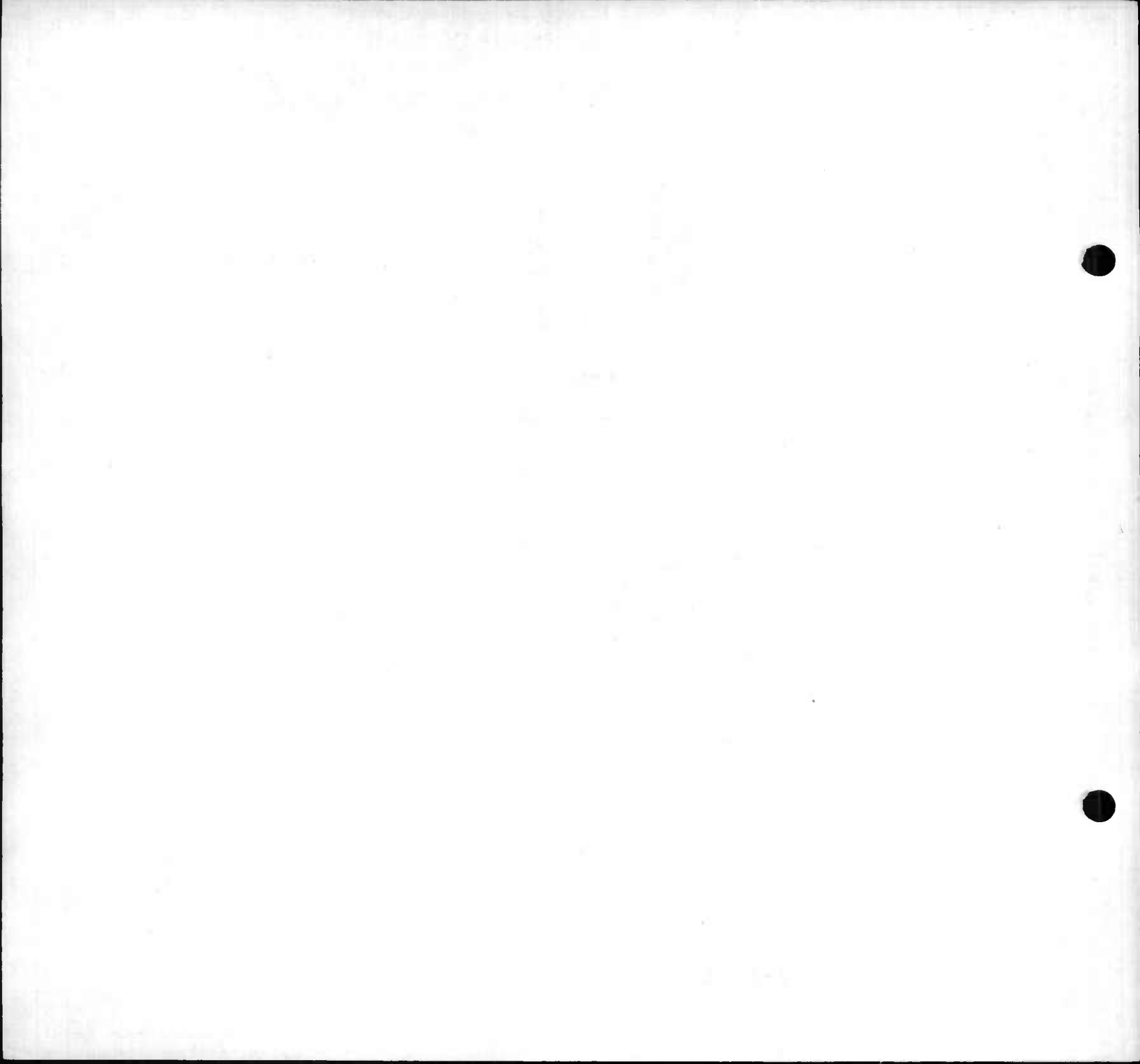
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09349 | |
|--|----------------------|---|---------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | Registered No. 66 09349 4 | |
| BIRTH NO. 66-12393 | | M.E. CASE NO. 66 09349 | | 2. DATE AND HOUR OF DEATH 8/31/66 11⁰⁰ A.M. | |
| 1. NAME OF DECEASED (Type or Print) Benne TT, Baby Boy | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3909 Wabash Ave. | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) - | 8. DATE OF BIRTH 8/31/66 | 9. AGE (In years last birthday) 6 | If Under 1 Yr. Months: Days: Hours: Min. 45 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) - | |
| 12. CITIZEN OF WHAT COUNTRY? - | | 13. FATHER'S NAME Fred Bennett | | 14. MOTHER'S MAIDEN NAME LeLia Black | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS - | |
| 18. 760.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRAIN Damage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1^o apnea | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/31 19 66 to 8/31 19 66 , that (I) (we) last saw the deceased alive on 8/31 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sanford Levin | | M.D. SANFORD LEVIN | | 23B. DATE SIGNED 8/31/66 | |
| 23C. PHYSICIAN'S NAME (Type) SANFORD LEVIN | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) - | | 24B. DATE 9-15-66 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) - | | 24E. (State) - | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

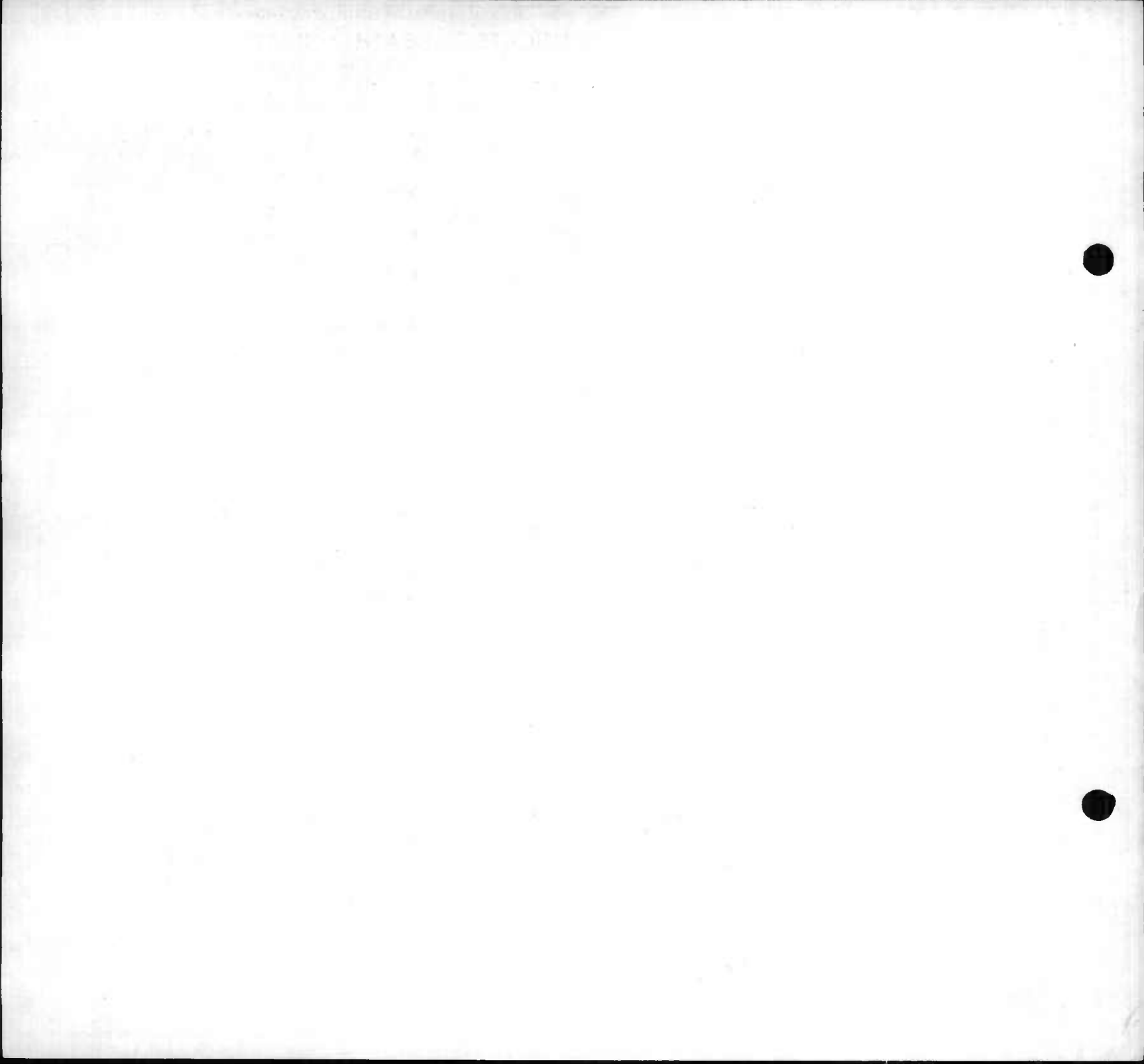
| | | | |
|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> B-346 66-18914 66 09350 </div> <div style="display: flex; justify-content: space-between;"> 66 09350 CERTIFICATE OF DEATH Registered No. 66 09350 </div> | | | |
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| BABY GIRL "B" Butler | | 9/6/66 6:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital | | A. STATE Md. B. COUNTY 15-13 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. | |
| | | D. STREET ADDRESS (If rural, give location) 2906 Ridgewood Ave., Balto., 15, Md. | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER | 8. DATE OF BIRTH 9/5/66 |
| 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? US |
| 13. FATHER'S NAME Leon Butler | 14. MOTHER'S MAIDEN NAME Shelia (?) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| 18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IMMATURITY | | INTERVAL BETWEEN ONSET AND DEATH 33 hrs 30 min | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/5/66 to 9/6/66, that (I) (we) last saw the deceased alive on 9/6/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Lloyd I. Kramer | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) LLOYD I. KRAMER | | 23D. ADDRESS SINAI Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 9-15-66 | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | 25B. NAME OF REGISTRAR Robert E. Fairley, M.D. | 25C. FUNERAL DIRECTOR ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 09351 4</u> | |
| BIRTH NO. <u>66 09351</u> | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>AUG. 28, 1966</u> <u>4:55 A.M.</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY BOY CONAWAY</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hosp. of Balt.</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>27-18</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3600 Lucille Ave</u> | |
| 5. SEX <u>male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>AUG. 27, 1966</u> |
| | | 9. AGE (In years last birthday) <u>-</u> | If Under 1 Yr. Months: Days: Hours: <u>11</u> <u>53</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>William Conaway</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | 14. MOTHER'S MAIDEN NAME <u>Foster</u> |
| | | 17. INFORMANT <u>Hospital chart</u> | ADDRESS |
| 18. <u>763X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>cardiac arrest</u> (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory failure</u> (B) DUE TO <u>pneumonia</u> (C) | | <u>11 hours</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u> |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u> |
| 21F. HOW DID INJURY OCCUR? <u>-</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>AUG 27, 1966</u> 19 to <u>AUG 28, 1966</u> 19, that (I) (we) lost saw the deceased alive on <u>AUG 28</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>(I) (we) (did) (did not)</u> view the body after death. | | | |
| 23A. SIGNATURE <u>Robert T. Devian</u> | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED <u>AUG. 28, 1966</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>-</u> | | 23D. ADDRESS <u>-</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>-</u> | 24B. DATE <u>9/15-66</u> | 24C. NAME OF CEMETERY or CREMATORY <u>-</u> | 24D. LOCATION (City, town, or county) (State) <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1966</u> | 25B. NAME OF REGISTRAR <u>-</u> | 25C. FUNERAL DIRECTOR <u>-</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

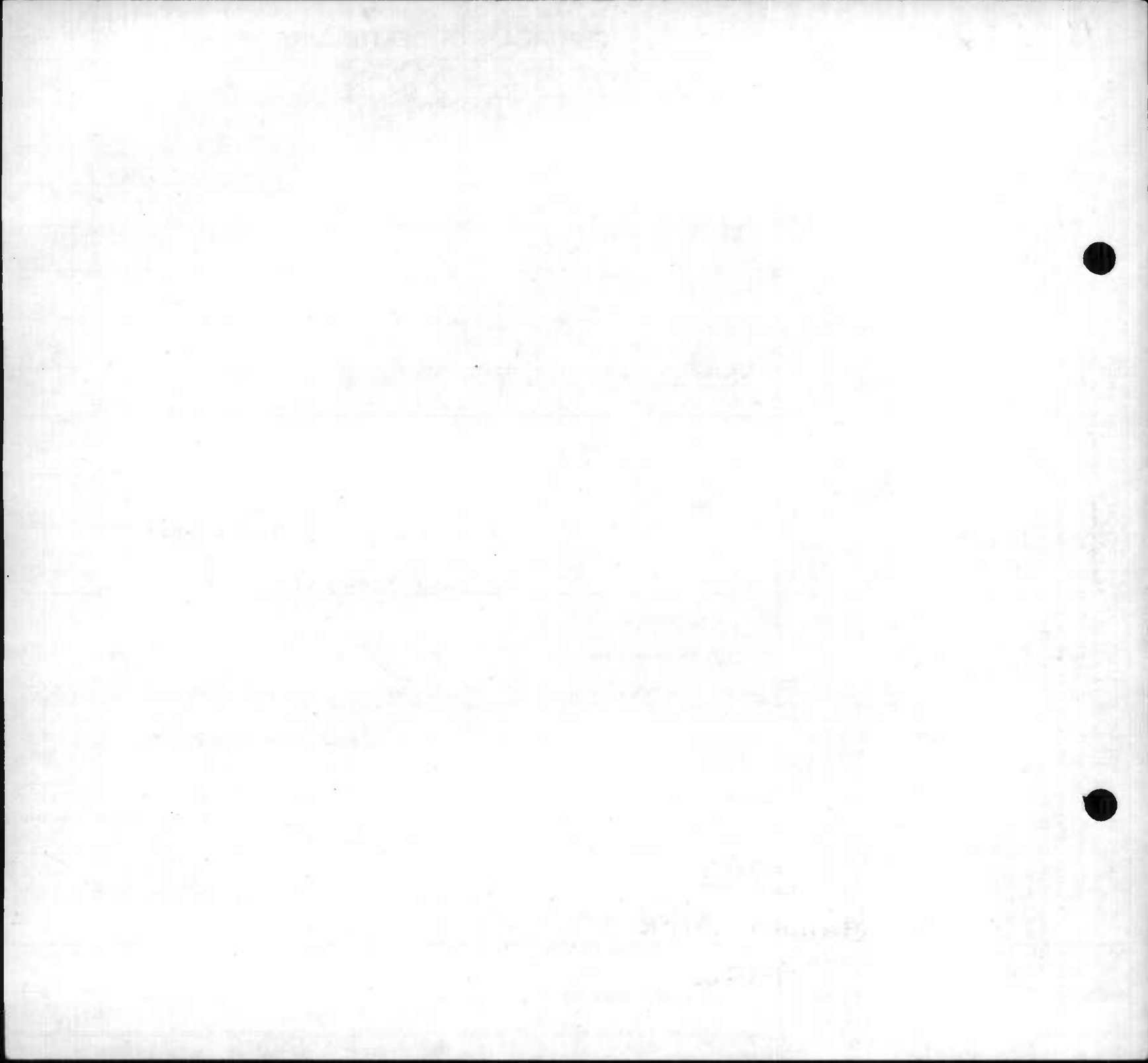
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>66 09352</u> | |
|---|----------------------|--|---------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. <u>66-18012</u> | | 66 09352 | | | | | |
| M.E. CASE NO. <u>66 09352</u> | | | | 1. NAME OF DECEASED (Type or Print) <u>Baby Boy Polly</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>Aug. 27, 1966 13:45 A.M.</u> | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore</u> | | | | A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> <u>53-00</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Owings Mills</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>118 Cedarmerse Rd.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>Aug. 21, 1966</u> | 9. AGE (In years last birthday) <u>-</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>- UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>- UNKNOWN Carol Polly</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Hospital chart</u> | | ADDRESS | |
| 18. <u>773.5T</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <u>respiratory failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> | |
| ANTECEDENT CAUSES | | | | (B) <u>Prematurity</u> | | <u>6 days</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>none</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>✓</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>no</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 21</u> 19 <u>66</u> to <u>Aug 27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Robert T. Bellman</u> M.D. | | | | 23B. DATE SIGNED <u>Aug 27, 1966</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) _____ M.D. | | | | 23D. ADDRESS _____ M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-15-66</u> | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1966</u> | | 25B. NAME OF REGISTRAR <u>92658. F. Bellman</u> | | 25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> | | ADDRESS <u>MORTUARY SERVICE - BOW</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. <u>66-108966 09353</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>66 09353</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) <u>Kim ELISE Miller</u> | | 2. DATE AND HOUR OF DEATH <u>SEPT. 10, 1966</u> <u>8⁵⁵</u> A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>48 md. GEN. Hosp.</u> | | A. STATE <u>md.</u> B. COUNTY <u>BALTIMORE</u> <u>53-00</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>PHOENIX</u> <u>2 2 1 3 1</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3 VALLEY GREEN COURT</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u> | 8. DATE OF BIRTH <u>MAY 25, 1966</u> | 9. AGE (In years last birthday) <u>3</u> <u>15</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>GARY Miller</u> | | | 14. MOTHER'S MAIDEN NAME <u>GRACE BRAIDEN BAUGH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>mother</u> ADDRESS <u>SAME</u> | |
| 18. <u>75311</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) <u>Congenital Heart Disease</u> DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Congenital Cerebral</u> DUE TO <u>anomalies & Cramostosis</u> | | | |
| | | (C) <u>Multiple Congenital Anomalies</u> <u>Adrenal hypoplasia</u> | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>✓</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>MAY 25</u> 19 <u>66</u> to <u>SEPT. 10</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 10</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Dick</u> | | | | 23B. DATE SIGNED <u>9/10/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Bernard Dick</u> | | | | 23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>9-15-66</u> | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR ADDRESS | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 16 1966 <u>John J. Fisher</u> MORTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

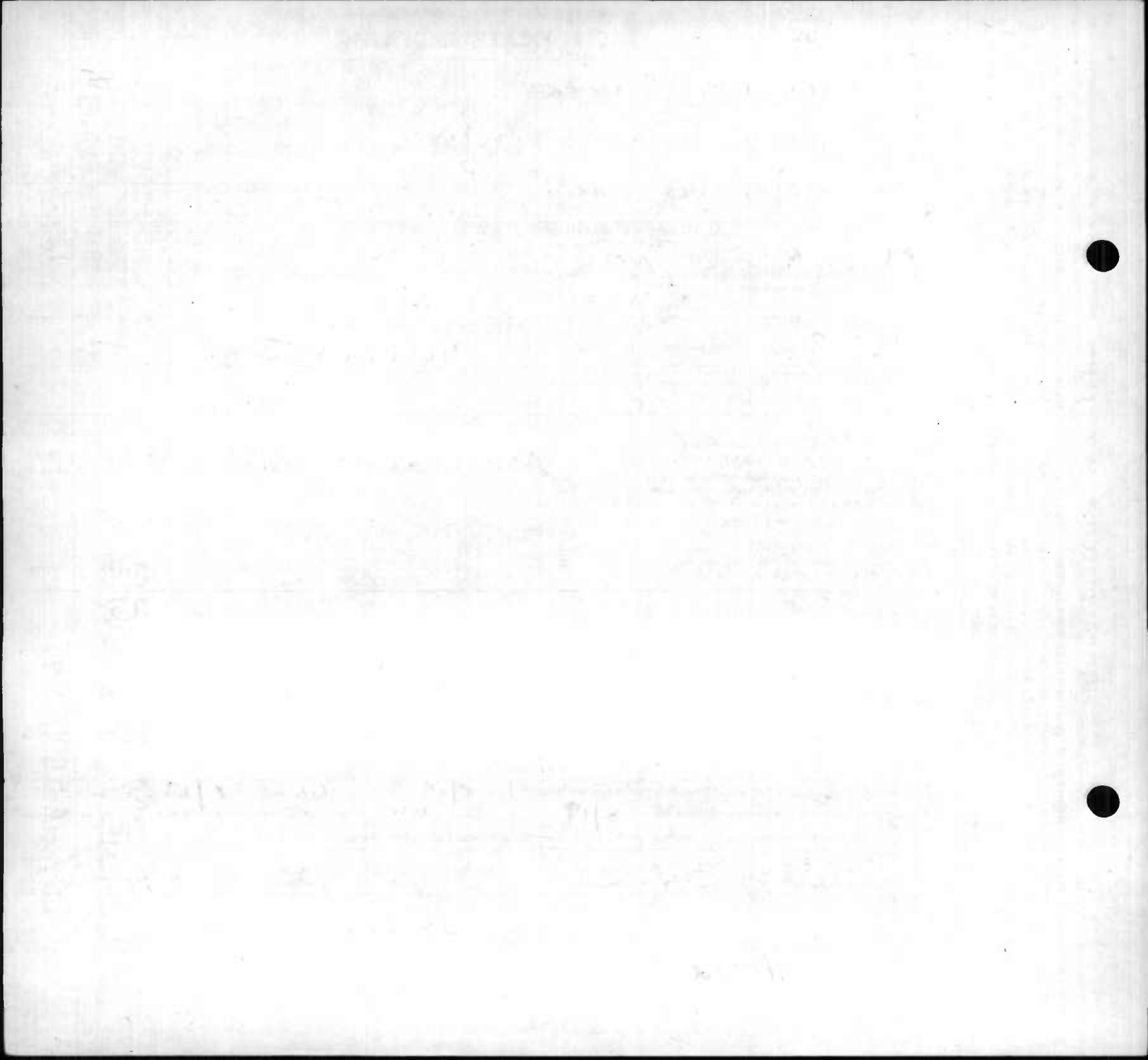
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|--|--|--|--|--|--|
| 66-23743 66 09354 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09354 | |
| BIRTH NO. | | 1. NAME OF DECEASED (Type or Print) <i>Baby Girl Evans</i> | | 2. DATE AND HOUR OF DEATH <i>July 27, 1966 1:35 P.M.</i> | |
| M.E. CASE NO. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>In Municipal Ambulance en route to 42/99 Sinai Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> 8. COUNTY <i>15-13</i> | |
| 5. SEX <i>Female</i> | | 6. RACE <i>Negro</i> | | 9. AGE (In years last birthday) <i>July 27, 1966</i> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>child</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>10 min</i> | |
| 13. FATHER'S NAME <i>Michael Evans</i> | | 14. MOTHER'S MAIDEN NAME <i>Mamie Ellis</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>primary asphyxia</i> DUE TO (B) <i>failure to deliver by cesarean section</i> DUE TO (C) <i>perforation</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>none</i> | | | | | |
| 19A. DATE OF OPERATION <i>2 0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>July 27</i> 1966 to <i>July 27</i> 1966, that (I) <u>(we)</u> last saw the deceased alive on <i>July 27</i> 1966 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) <u>(did not)</u> view the body after death. | | | |
| 23A. SIGNATURE <i>Allen Manfred</i> M.D. | | 23B. DATE SIGNED <i>7/27/66</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Allen Manfred</i> | | 23D. ADDRESS <i>Sinai Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>9-15-66</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county, and state) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>SEP 16 1966</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. MORTUARY SERVICE - BCHD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

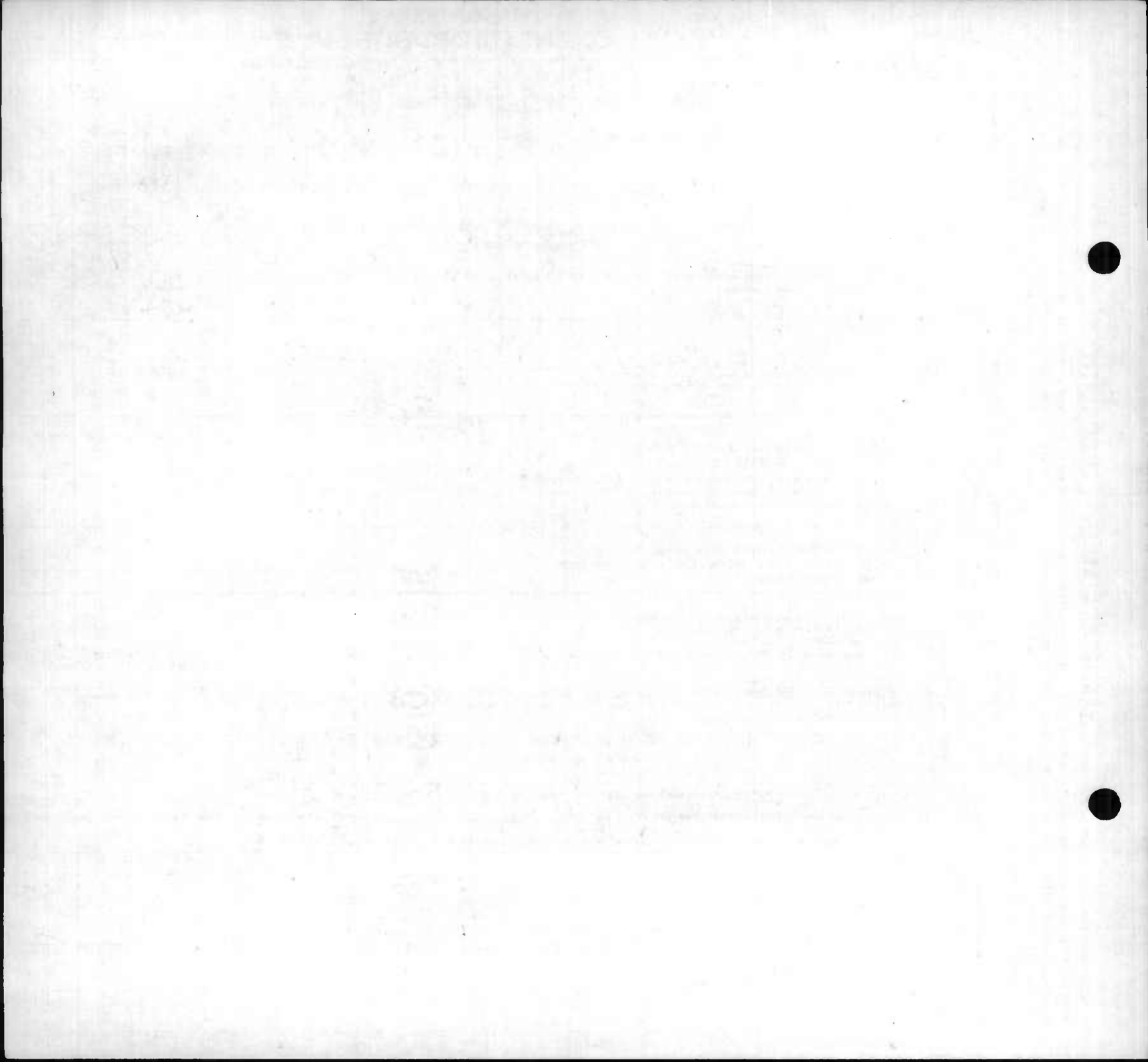
| | | | | | |
|---|---------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 09355 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09355 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BABY BOY SIMMONS | | 2. DATE AND HOUR OF DEATH 8/19/66 4:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 16-01 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | D. STREET ADDRESS (If rural, give location) 1018 BROOKFIELD AVE. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NM. | 8. DATE OF BIRTH 8-19-66 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days Hours Min. 4 45 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY infant | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | 13. FATHER'S NAME Albert T. Simmons | | 14. MOTHER'S MAIDEN NAME DELORES Simmons Hutton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 771.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE HEMORRHAGE. | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 445/60 HRS. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>my</u> (this hospital) attended the deceased from 8/19 19 66 to 8/19 19 66 , that <u>my</u> (we) last saw the deceased alive on 8/19 19 66 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I) (We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert T. Simmons | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9/13/66 | | 24C. NAME of CEMETERY or CREMATORY City Superior | |
| 24D. LOCATION (City, town, or county) (State) | | ANATOMY BOARD OF MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL | |
| SEP 16 1966 DEPT. OF HEALTH SMUTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|--------------------------------|
| 66-1187166 09356 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09356 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Mc Cloud, Baby Girl | | 8/22/66 11:30 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 28 University Hosp | | Newborn 7-04 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore, Md. | | 1831 GAGER ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | C | newborn | 8/22/66 | 6 | 1 27 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Newborn | | | | Balt., Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Willie McCloud | | Barbara McCloud Chandler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | n/a | | chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| 776X1 | | (A) Immaturity | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/22 1966 to 8/22 1966, that (I) (we) last saw the deceased alive on 8/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Martha Loffler | | | | 8/22/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Martha Loffler | | University Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | 9-13-66 | | ANATOMIC | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | J. J. Taylor, M.D. | | UNIVERSITY MEDICAL SCHOOL | |
| MORTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

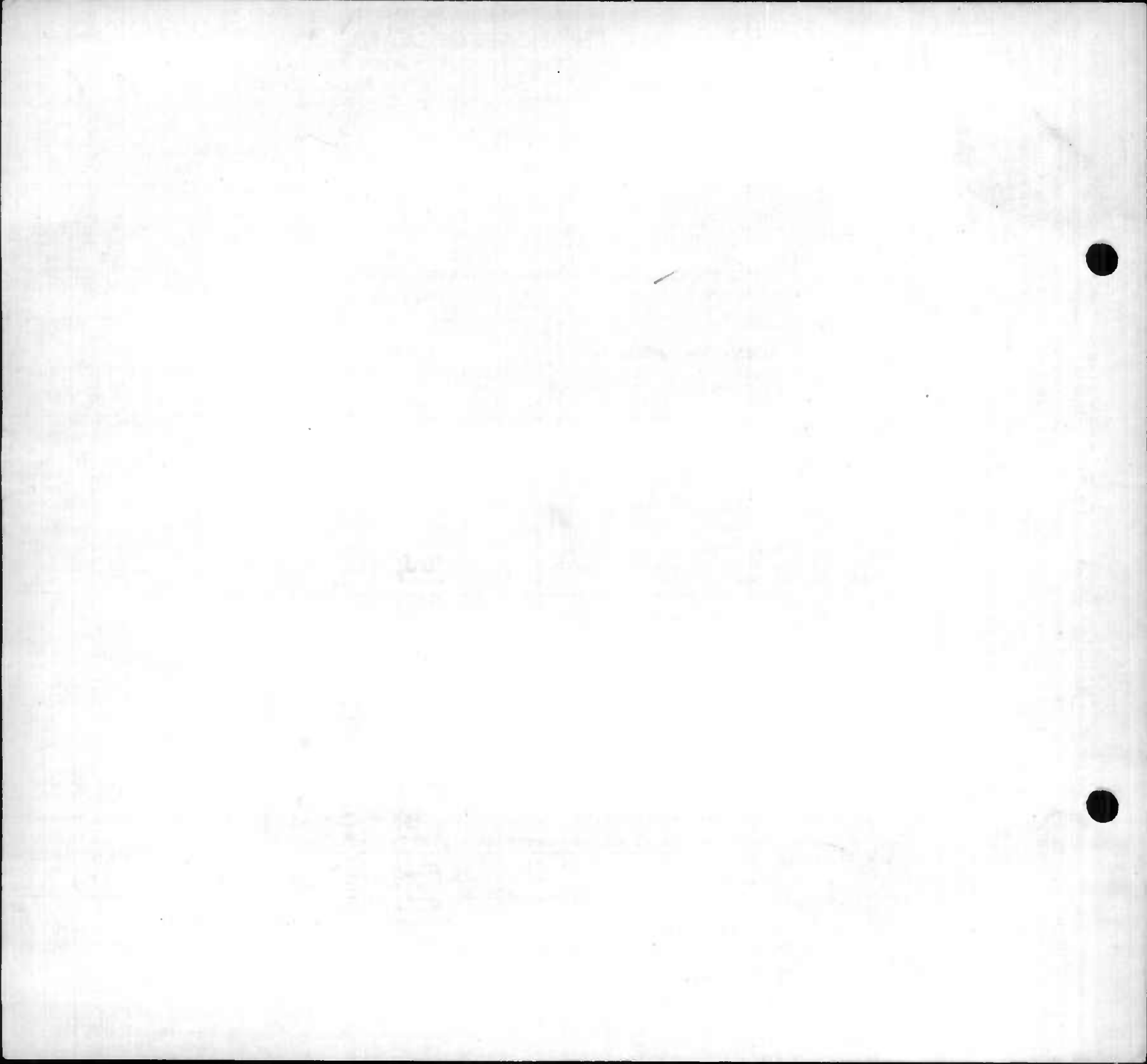
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------------------|--|---|---|---|
| BIRTH NO. 17848 66 09357 | | CITY HEALTH DEPARTMENT BALTIMORE CITY | | Registered No. 66 09357 4 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Garlick, Baby Girl</i> | | 2. DATE AND HOUR OF DEATH <i>8-28-66 4:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>25-33</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2217 Cedley St.</i> | | | |
| 5. SEX <i>♀</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i> | 8. DATE OF BIRTH <i>8-28-66</i> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Ralph H. Garlick</i> | | 14. MOTHER'S MAIDEN NAME <i>Lois Garlick</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>-</i> | 17. INFORMANT <i>Chad</i> ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>776X I</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Immaturity</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>-</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>-</i> | |
| 22. I certify that the (this hospital) attended the deceased from <i>1:30pm 8-28-66</i> to <i>4:30pm 8-28-66</i> , that the (we) last saw the deceased alive on <i>8-28-66</i> and that in (my) the opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE <i>Edward J. Ruley, MD</i> | | | | 23B. DATE SIGNED <i>8-28-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Edward J. Ruley, MD</i> | | | | 23D. ADDRESS <i>University Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>8-13/66</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i> | |
| 24D. LOCATION (City, town, or county) <i>MARYLAND</i> | | (State) <i>(State)</i> | | 25A. DATE REC'D BY HEALTH DEPT. | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS <i>MORTUARY SERVICE - BCHD</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------------------------|--|--|---|---|
| BIRTH NO. 66 09358 M.E. CASE NO. | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09358 4 | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY ROBINSON | | | 2. DATE AND HOUR OF DEATH AUGUST 29, 1966 2 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL OF MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 13-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21217 D. STREET ADDRESS (If rural, give location) 2225 1/2 Linden Ave | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH AUGUST 29, 1966 | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? 2 23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME ISSARD ROBINSON BALLARD | | | 14. MOTHER'S MAIDEN NAME ANNIE Robinson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS MOTHER 2225 1/2 LINDEN AVE, #17 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 776X1 PREMATURITY | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours 23 min | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 18. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 29 19 66 to AUGUST 29 19 66 , that (I) (we) last saw the deceased alive on AUGUST 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. Hernandez | | | | 23B. DATE SIGNED AUGUST 29, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) HUMBERTO C. HERNANDEZ | | | 23D. ADDRESS UNIVERSITY HOSPITAL OF MARYLAND | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9-13-66 | | 24C. NAME OF CEMETERY or CREMATORY CITY DISPOSAL | |
| 24D. LOCATION (City, town, or county) (State) | | UNIVERSITY MEDICAL SCHOOL | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1966 | | 25B. NAME OF REGISTRAR Dr. J. S. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD | |



66 09359

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09359

BIRTH NO.

M.E. CASE NO.

SAVERIO

1. NAME OF DECEASED
(Type or Print)

GUIDO

SCALET

2. DATE AND HOUR PRONOUNCED DEAD

September 1, 1966

3:30 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

700 FLEET ST - 3-02

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

S.S. Alberto Bennati

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Italy

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Province of Trento

D. STREET ADDRESS (If rural, give location)

NICOLETTI # 26

TRANSACQUA DI PREMIERO VIA DON

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

SEPT. 12 1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
during most of working life, even if retired)

SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

SHIPPING

11. BIRTHPLACE (State or foreign country)

REVERETO ITALY

12. CITIZEN OF
WHAT COUNTRY?

ITALY

13. FATHER'S NAME

SCALET

14. MOTHER'S MAIDEN NAME

CANDIDA SCALET

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

VENICE

16. SOCIAL
SECURITY NO.

MATR. 14173

17. INFORMANT

ADDRESS

LAVSHIP OF BALTO. INC. COURT BQ. BQ

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Cause of death not demonstrated due
to decomposition of body. Probable
cause: brainstem trauma and/or
aspiration of sea water.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Ship at sea

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)S.S. Alberto Bennati 100 miles
off Cape Hatteras21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9-1-66 about 2:20 A.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐21F. HOW DID INJURY OCCUR? Wave hit ship and
washed victim down passageway

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Sprigate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 11, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

SEPT. 1966

23C. NAME OF CEMETERY or CREMATORY

TRANSACQUA

23D. LOCATION

(City, town, or county)

PROVINCE OF TRENTO ITALY

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

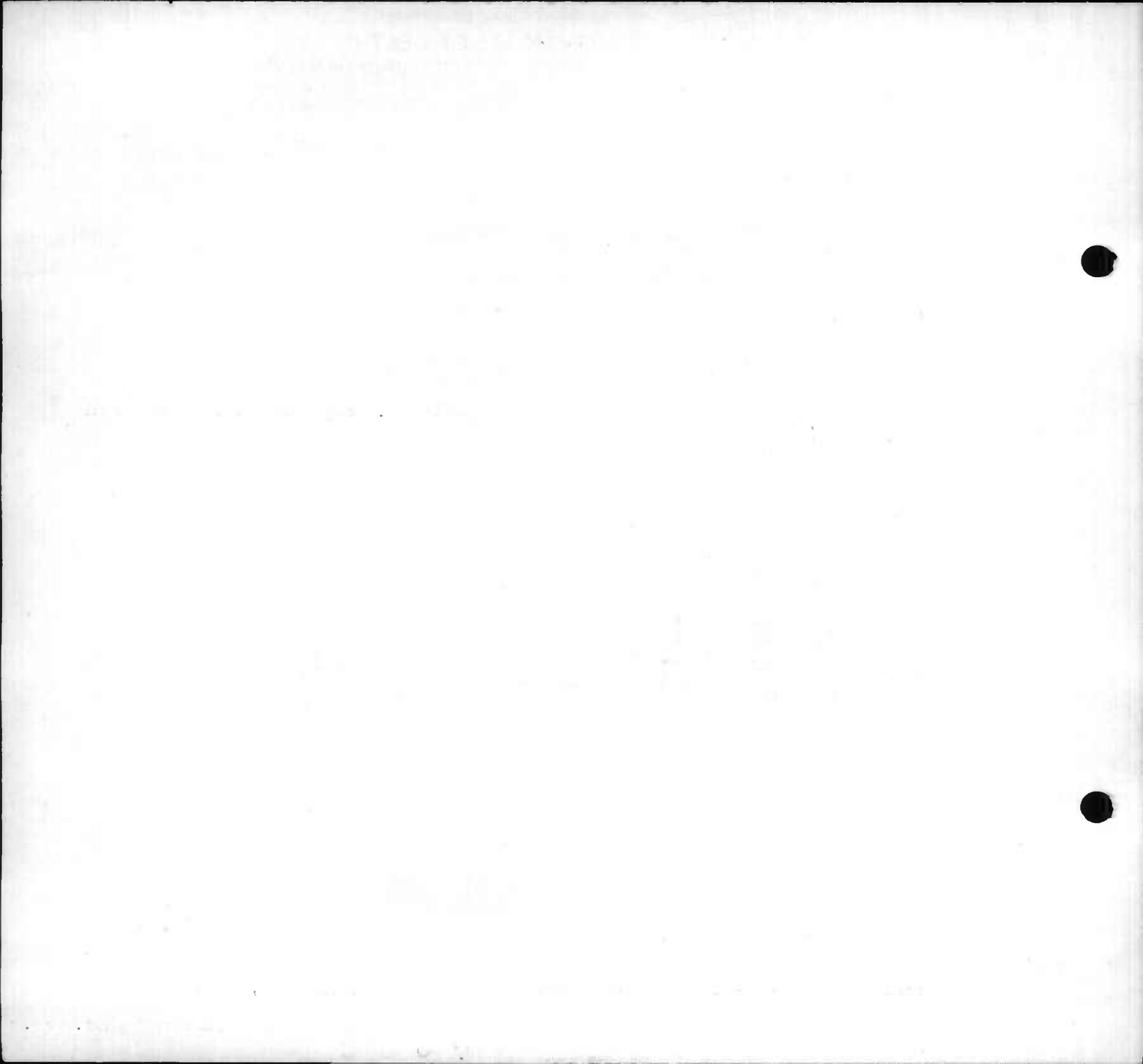
ADDRESS
322 S. HIGH ST

WALTON
FORD
M

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

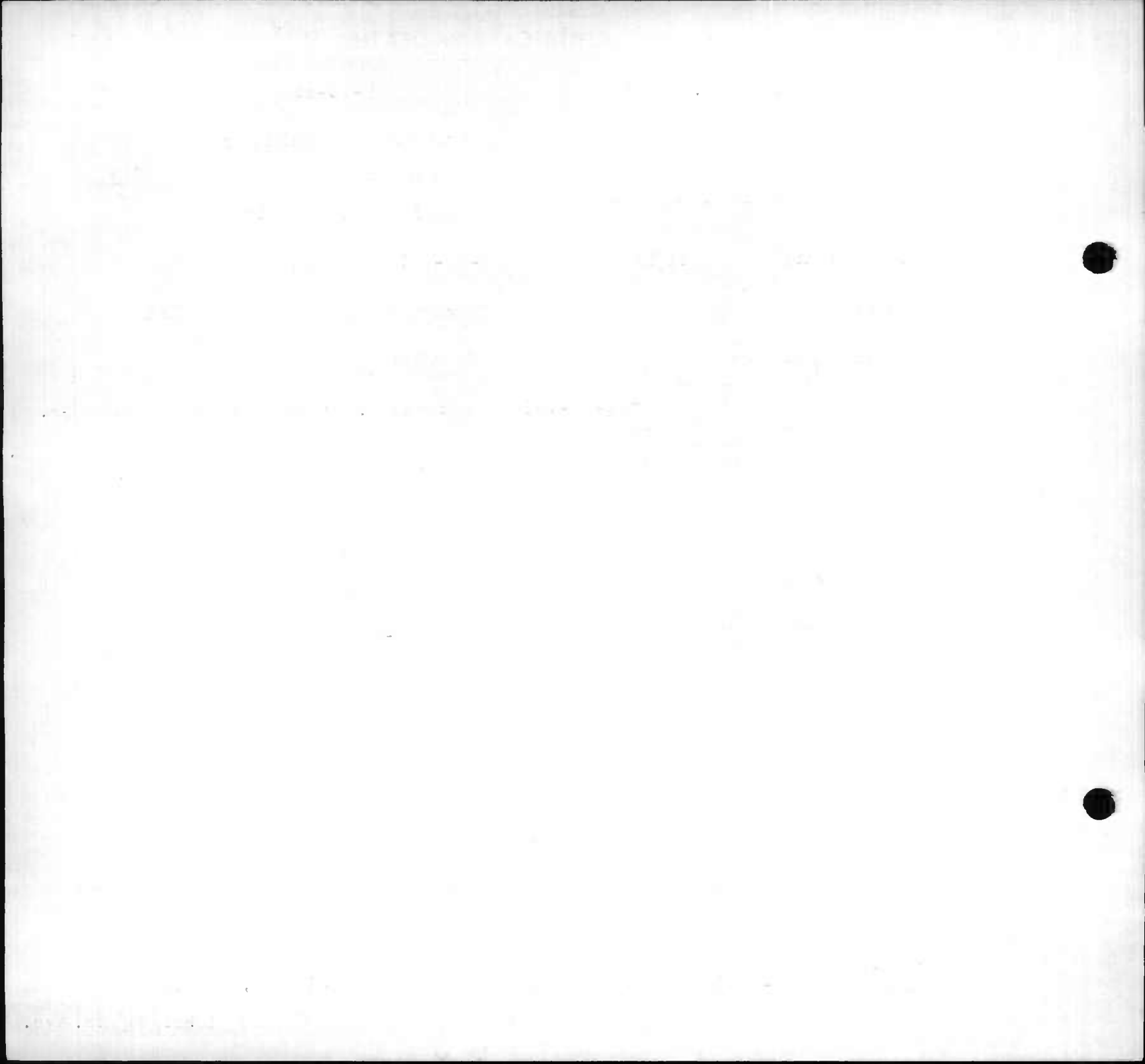
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---|--|
| 66 09360 | | CERTIFICATE OF DEATH | | 66 09360 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) L. BRENT FREY | | | 11:40 AM Sept. 16, 1966 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSPITAL BALTIMORE, MD. | | | A. STATE NEW JERSEY B. COUNTY SPARTA | | |
| 5. SEX M | | | 6. RACE W | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 3-20-'91 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O manager | | | 9. AGE (In years last birthday) 74 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) W. VIRGINIA | | |
| 13. FATHER'S NAME LEWIS FREY | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Nellie W. Frey | | | ADDRESS 268 East Shore Trail | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.11 BRONCHOGENIC CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO BRONCHOGENIC CARCINOMA METASTATIC TO LIVER (B) DUE TO L (C) | | |
| 19A. DATE OF OPERATION 7-19-66 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHOGENIC CARCINOMA | | |
| 20A. AUTOPSY? (Yes or No) YES | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) — | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — | | |
| 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | | 21F. HOW DID INJURY OCCUR? — | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-19-66 to 9-16-66 , that (I) (we) last saw the deceased alive on 9-16-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E. C. MARIANO, M.D. | | | 23B. DATE SIGNED 9-16-66 | | |
| 23C. PHYSICIAN'S NAME (Type) IDILIA C. MARIANO | | | 23D. ADDRESS CHURCH HOME + HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbanks | | 25C. FUNERAL DIRECTOR Ellsworth Anacost | | ADDRESS 4600 Liberty Hgts. Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09361</u> | |
|--|--|--|--|--|--|
| 66 09361 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Elfriede M. Kuebler | | 9-16-66 12:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 90 Belvedere House in the Pines | | Baltimore | | D. STREET ADDRESS (If rural, give location) | |
| 2006 Woodlawn Drive | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | White | | Single | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Dietician | | | | Germany | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Kuebler | | Unknown | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 212-32-7698 | | Anthony V. Demanss 2006 Woodlawn Dr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.) | | (A) DUE TO | | 70 yrs | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Arterio-sclerotic C.V.D. | | 10 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 none | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| no | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1940 to Sept-16-1966 that (I) (we) last saw the deceased alive on 9-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Duer Moores | | | | 9-17-66 | |
| 23C. PHYSICIAN NAME (Type) | | | | 23D. ADDRESS | |
| J. Duer Moores | | | | 3105 Belair Rd. 21213 | |
| 24A. BURIAL CREMATION | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Cremation | | 9-19-66 | | Loudon Park Cemetery | |
| 24D. LOCATION | | 24E. LOCATION | | 24F. LOCATION | |
| Baltimore, Maryland | | Baltimore, Maryland | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 19 1966 | | R. E. Falkner | | 4600 Liberty Hghts. Ave. | |



WALLLEY FORTUNE

RAILROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-----------------------------|--|---|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>66 09363</u> | | | | |
| BIRTH NO. <u>66 09363</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Baby McCormick</u> | | | | | 2. DATE AND HOUR OF DEATH <u>9/15/66 4⁰⁰</u> <u>A</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hosp</u> | | | | | A. STATE <u>MD.</u> , B. COUNTY <u>Balto</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> <u>53-00</u> | | | | |
| D. STREET ADDRESS (If rural, give location) <u>1424 Forrest Park Ave</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>9/14/66</u> | 9. AGE (In years last birthday) <u>9</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New Born</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>James Francis McCormick</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Agnes Bauer</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT <u>James McCormick</u> | | | ADDRESS <u>Same as #4</u> | |
| 18. <u>761.5</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u> | | | | | CAUSE OF DEATH (A) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH <u>25 wk gest</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Placental previa partial</u> <u>Placental abruption</u> | | | | | (B) DUE TO | | | (C) <u>25 wk</u> <u>2 wk</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>8</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/14/66</u> 19 to <u>9/15/66</u> 19, that (I) (we) last saw the deceased alive on <u>9/14/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Charles E. Collins M.D.</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>9/15/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/17/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | | 25B. NAME OF REGISTRAR <u>Wm Cook-Brooks</u> | | 25C. FUNERAL DIRECTOR (ADDRESS) <u>1217 St. Paul St Baltimore, Md.</u> | | | | |

7 - General Water Survey 9/14/12 9/12/12

424

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Wm. A. R. 1891

5

getrost

1000

10/2/10

10/10/10

22/10/02

X

D 553

66 09364

BALTIMORE CITY HEALTH DEPARTMENT

66 09364

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | | | | | |
|---|---------|--|------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| ROSE A. DIAMOND | | | | September 16, 1966 10:53 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE Maryland | | | |
| Union Memorial Hospital | | | | B. COUNTY 13-08 | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3813 Conduit Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| Female | White | Married | 8/6/08 | 58 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own Home | | New York | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Patrick Conroy | | | | Mary McElroy | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | McKeon Funeral Home Bronx, N.Y. | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 9/17/66 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/21/66 | | Gate of Heaven | | Mt Pleasant, New York | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | | | |
| SEP 19 1966 | | Wm. Cook-Brooks Inc. Baltimore, Md. | | | | | |

WALTER H. TOFFER

1
W-420

66 09365

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09365

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JERRY Dean WILES

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966 1:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE North Carolina B. COUNTY V-30

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Lansing

D. STREET ADDRESS (If rural, give location)

Route 3

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 7, 1946

9. AGE (In years last birthday)

19

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Lillard Wiles

14. MOTHER'S MAIDEN NAME

Della Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Lillard Wiles, Lansing, N. C.

18.

E 823.14

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rt. 22, E. of Churchville, Harford Co.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 9 12 '66 P M.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto which ran off roadway.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

9/18/66

23C. NAME of CEMETERY or CREMATORY

West Jefferson

23D. LOCATION

(City, town, or county)

(State)

West Jefferson, N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

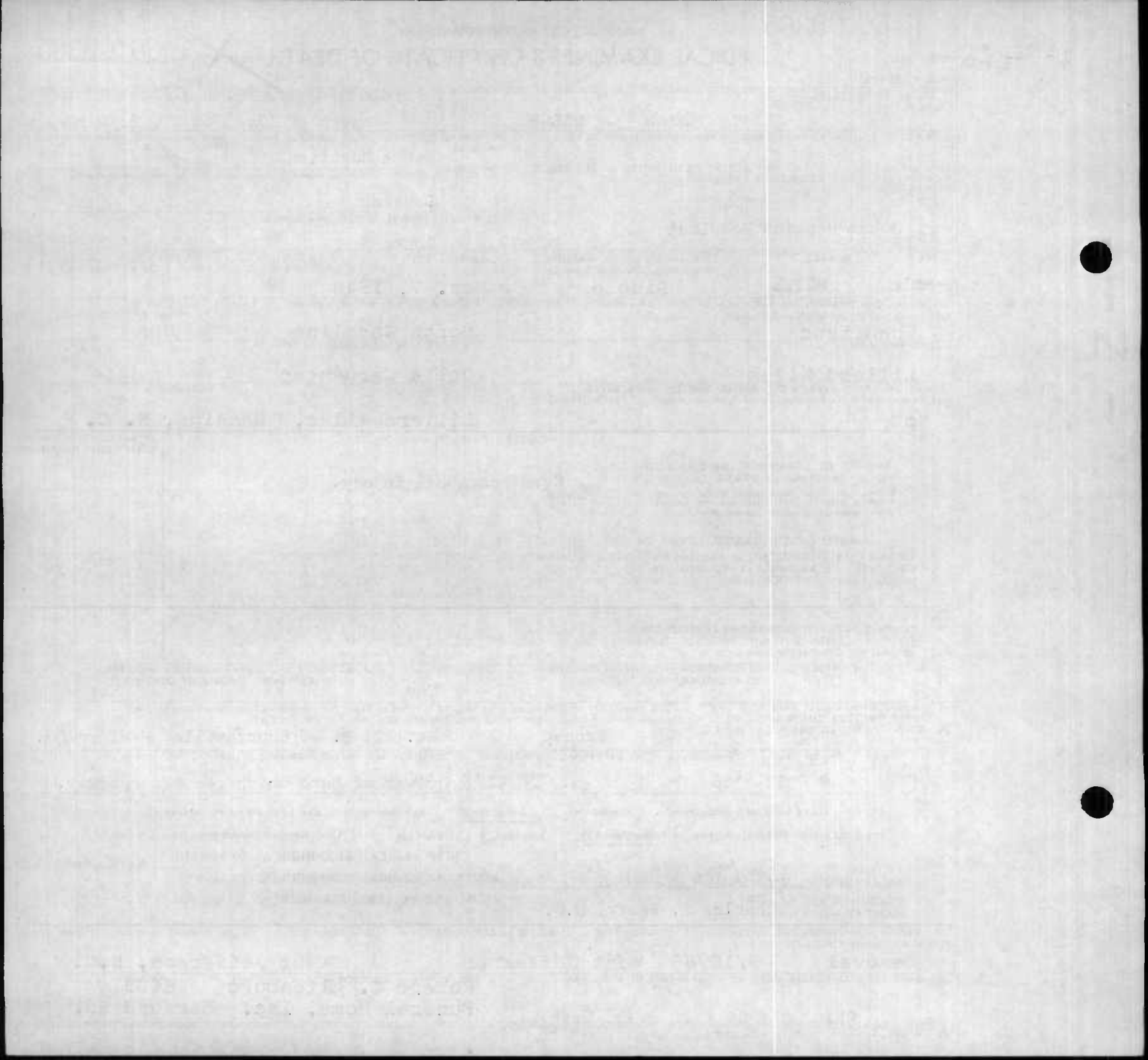
Robert C. Altenburg

ADDRESS

Funeral Home, Inc. Harford Rd.

SEP 19 1966

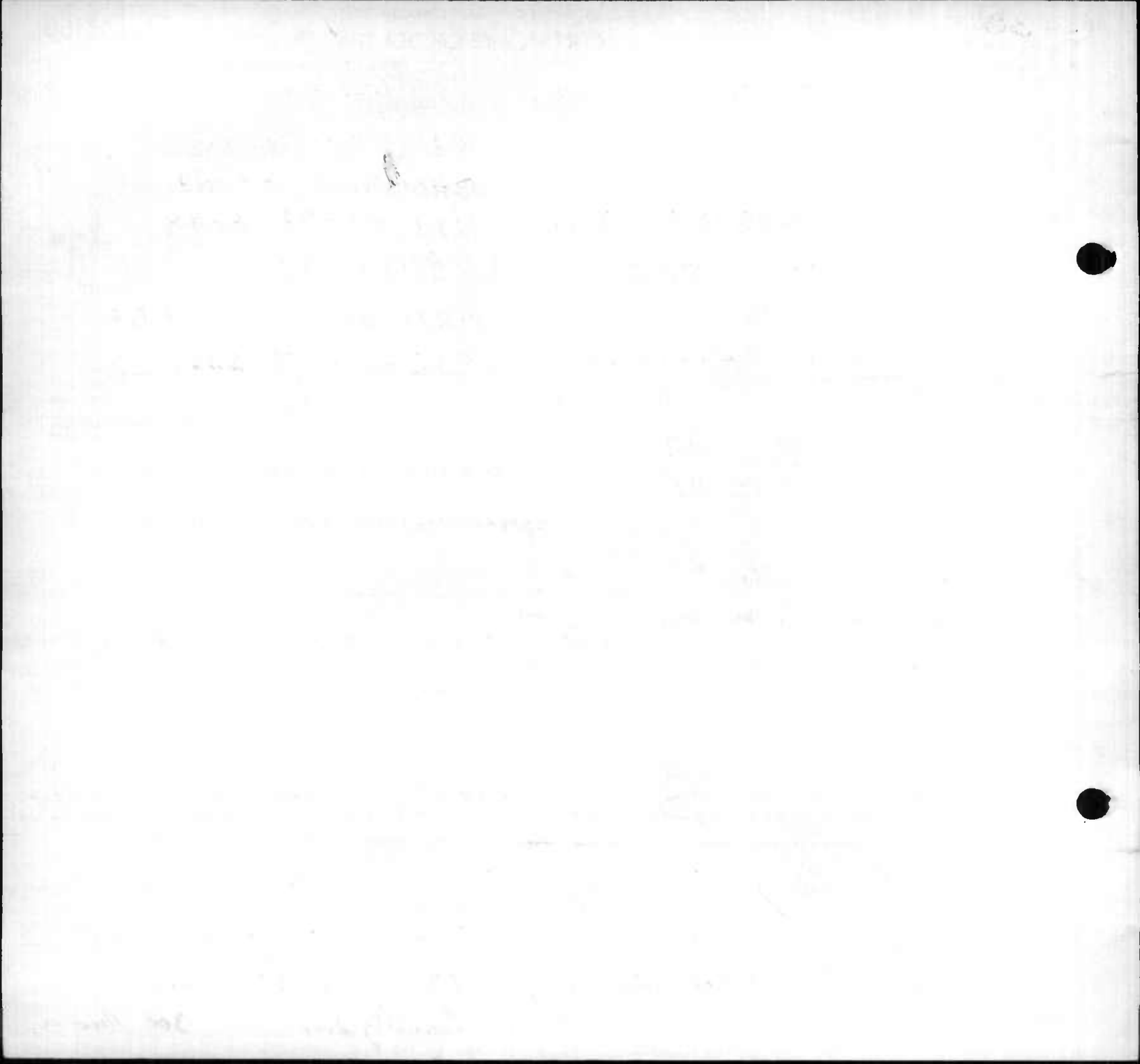
66 09365



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

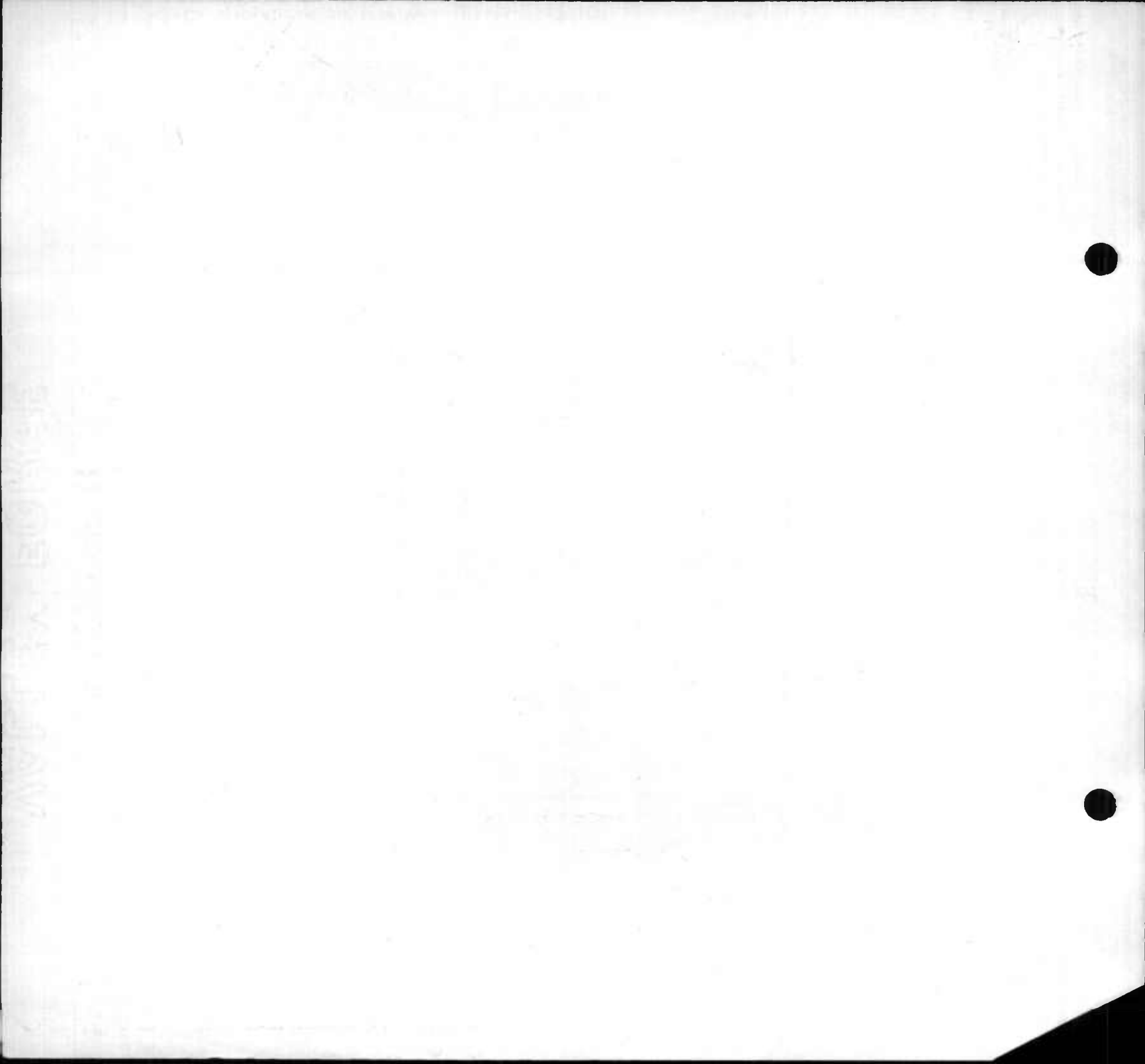
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-----------|--|------------------|--|------------------------------|
| 66 09366 | | 66 09366 | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| GOOD, CATHERINE NMN | | 15 SEPT 66 4:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 44 UNION MEMORIAL HOSP. | | MD. BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 20 MD 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1119 OREMS ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | W | WIDOWED | 10/15/92 | 73 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| ADMINISTRATIVE | | | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| JOSEPH NARTMAN | | BARBARA ECHART | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| unk | | UNK | | | |
| 18. 332 X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) CEREBRAL THROMBOSIS | | 9 days | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) ARTERIOSCLEROTIC VASCULAR DISEASE | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 2 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | BRONCHIAL PNEUMONIA | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6 SEPT 1966 to 15 SEPT 1966, that (I) (we) last saw the deceased alive on 15 SEPT 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| SIDNEY E. KIRKLEY M.D. | | | | 15 SEPT 66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| SIDNEY E. KIRKLEY M.D. | | | | UNION MEMORIAL HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 9/19/66 | Garden of Faith | | Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 19 1966 | | Robert E. Faldut | | Connolly Sons 300 Moore | |



FUNERAL DIRECTOR: IMPORTANT

Certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

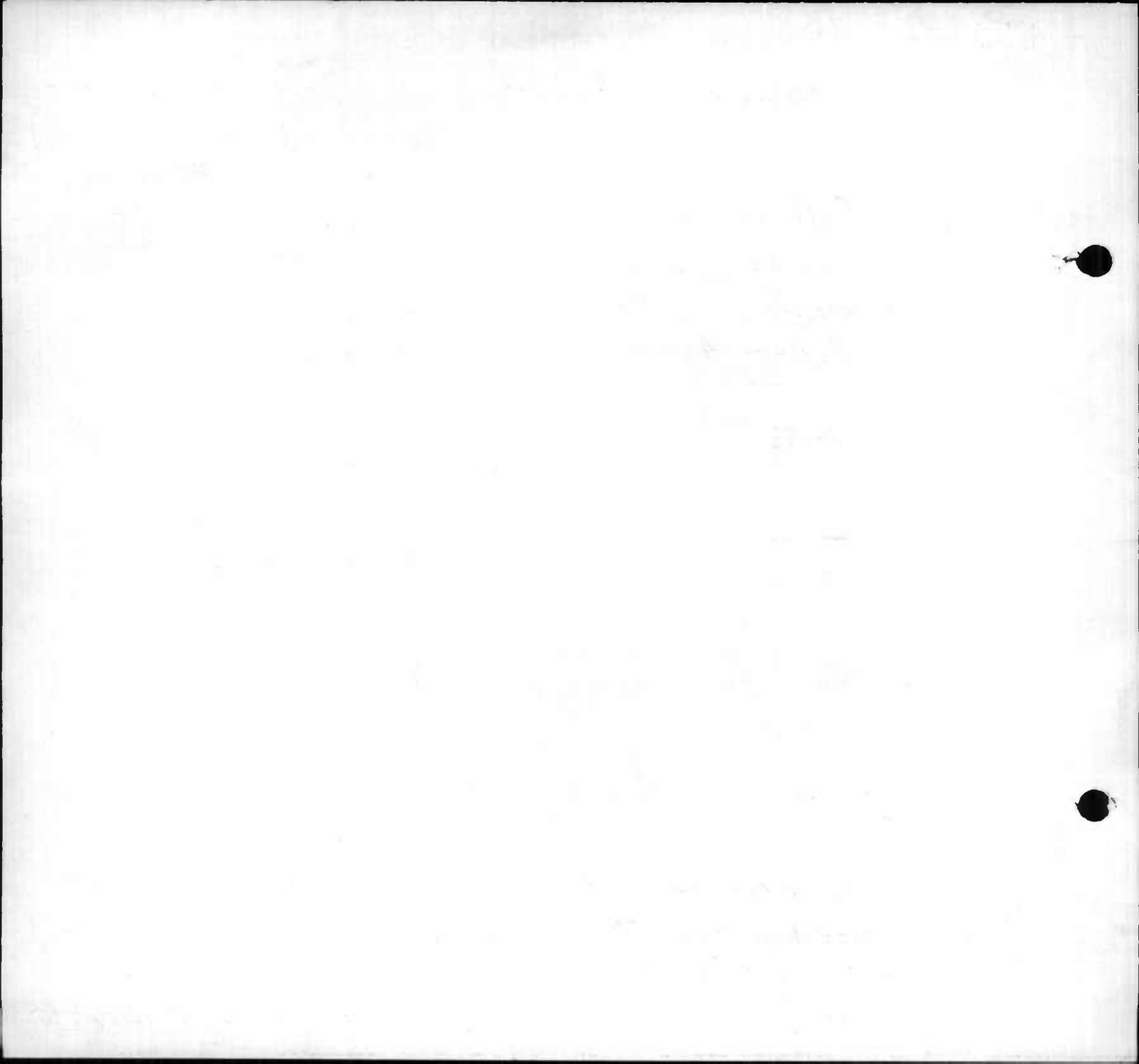
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09367</u> | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. <u>66 09367</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>JAMES STEPHENS.</u> | | | | 2. DATE AND HOUR OF DEATH <u>Sept. 12, 1966 17⁴⁵ P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hospital</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Savage</u> <u>63-00</u> | |
| D. STREET ADDRESS (If rural, give location) <u>206 Commercial St.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>separated</u> | 8. DATE OF BIRTH <u>10/17/07</u> | 9. AGE (In years last birthday) <u>58</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Sanford Stephens</u> | | | 14. MOTHER'S MAIDEN NAME <u>Bertla Arkeman</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>213-03-4681</u> | | 17. INFORMANT <u>Medical Records</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>147X I</u> <u>Carcinoma of larynx</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>months</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> 19 <u>66</u> to <u>Sept 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Barry N. Rosenbaum</u> | | | | 23B. DATE SIGNED <u>9/12/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARRY N. ROSENBAUM</u> | | | | 23D. ADDRESS <u>MONTABELLO HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/16/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Dorsey Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>McWitt-Danaher, Daniel M.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

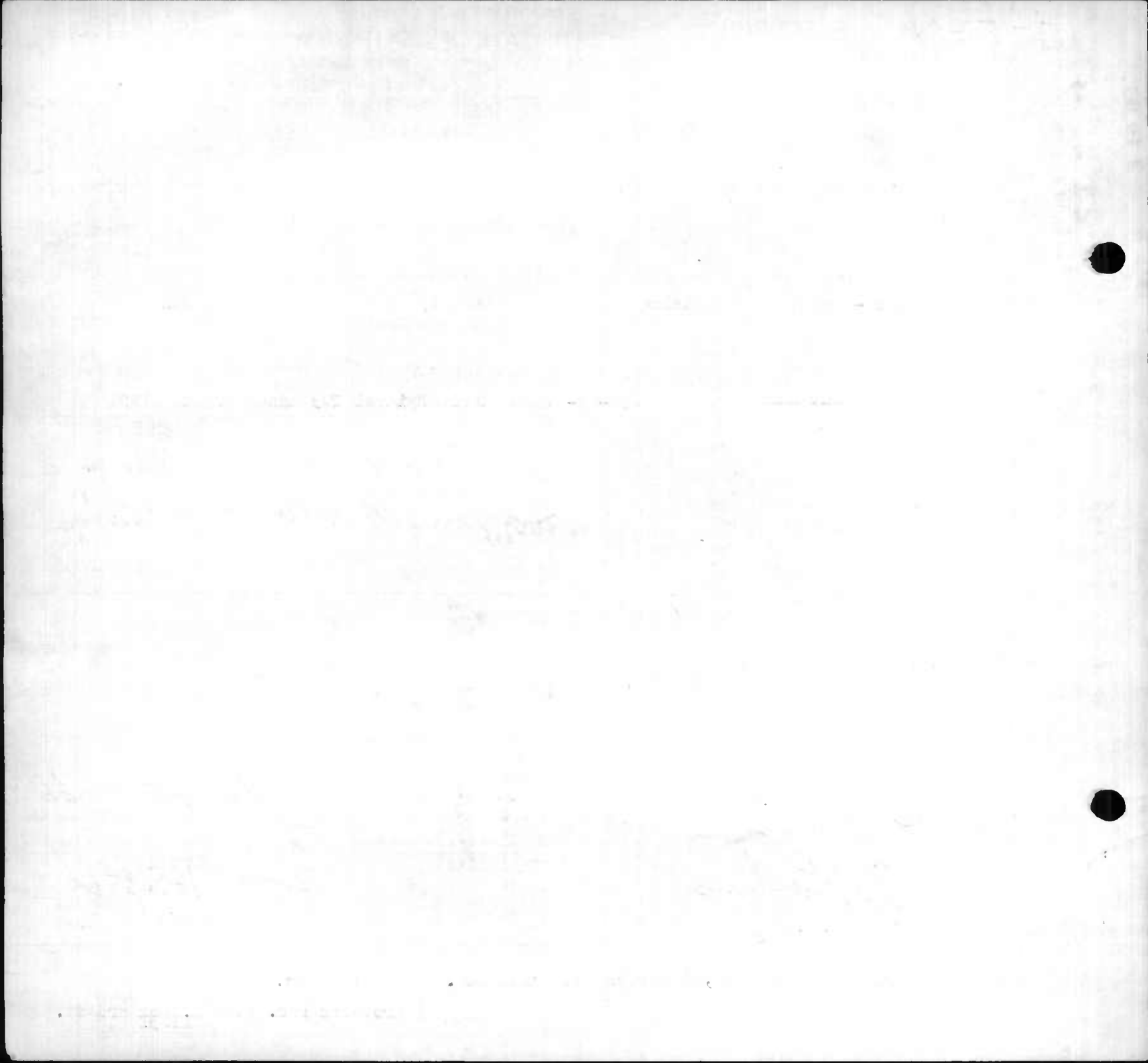
| | | | | | |
|---|--|--|---|--|---|
| BIRTH NO. 66 09368 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09368 | |
| 1. NAME OF DECEASED (Type or Print) Sadie R. Abbott | | | 2. DATE AND HOUR OF DEATH 9-16-1966 12:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 23-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230 D. STREET ADDRESS (If rural, give location) 1226 S. Hanover St. | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 9-1-84 | 9. AGE (In years last birthday) 82 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME ALBERT ABBOTT | | | 14. MOTHER'S MAIDEN NAME Sarah | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. 5020 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pneumonia | | | CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Bronchitis + Emphysema (C) Arteriosclerotic Cardiovascular | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that the this hospital) attended the deceased from 9-4 19 66 to 9-16 19 66 , that we (we) last saw the deceased alive on 9-16 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stephen Hameroff M.D. | | | 23B. DATE SIGNED 9-16-66 | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) Stephen Hameroff, M.D. | | | 23D. ADDRESS South Baltimore General Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE 9/19/66 | 24C. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK. | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | 25B. NAME OF REGISTRAR Robert E. Farber | 25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 LIGHT ST. | | | |



FUNERAL DIRECTOR: IMPORTANT

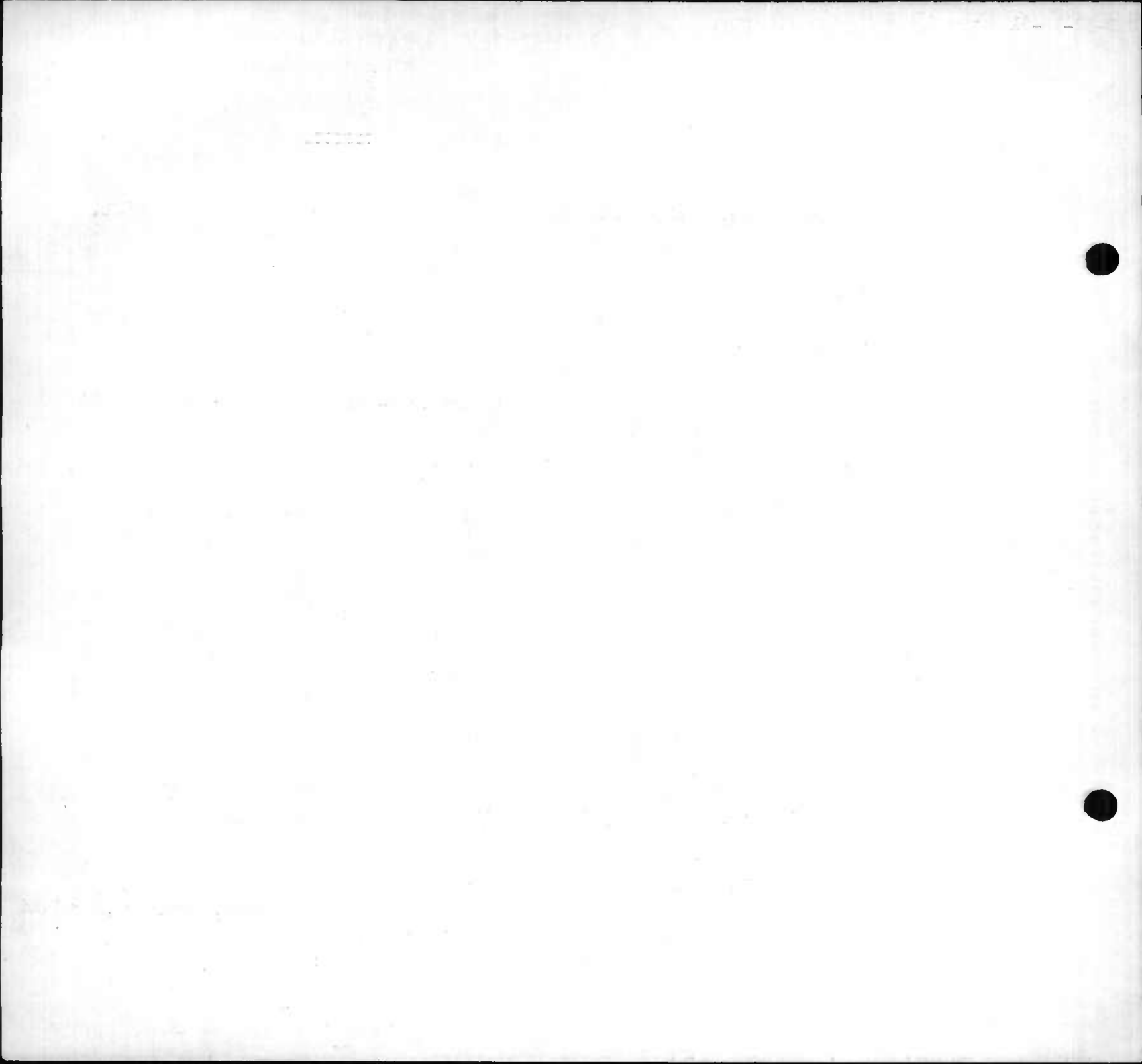
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09369 | |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 09369 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) LESLIE ENGEL | | 2. DATE AND HOUR OF DEATH 9-16-66 1.00 A <small>M.</small> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND B. COUNTY 25-04 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3703 6TH STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWER | 8. DATE OF BIRTH 12-12-82 | 9. AGE (In years last birthday) 83 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner - Labor | | 10B. KIND OF BUSINESS OR INDUSTRY Mining | | 11. BIRTHPLACE (State or foreign country) Hungary | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME ANDREW ENGEL | | 14. MOTHER'S MAIDEN NAME MARIE KEREKES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 236-07-4726A | | 17. INFORMANT ADDRESS Maria Nyitrai 203 Essex Avenue 21221 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHIAL PNEUMONIA | | CAUSE OF DEATH (A) DUE TO BRONCHIAL PNEUMONIA (B) DUE TO EMPHYSEMA OF THE GALL BLADDER - 9 days (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION Sept 66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 25 Aug 66 19 to 16 Sept 19 66 . that (I) (we) last saw the deceased alive on 16 Sept 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W.B. Sams | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 16 Sept 66 | |
| 23C. PHYSICIAN'S NAME (Type) W.B. SAMS | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 19, 66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | |
| 24D. LOCATION Balto Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Fagley | | 25C. FUNERAL DIRECTOR ADDRESS Dippel Brothers Inc. 1800 E. Lombard St. 21231 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

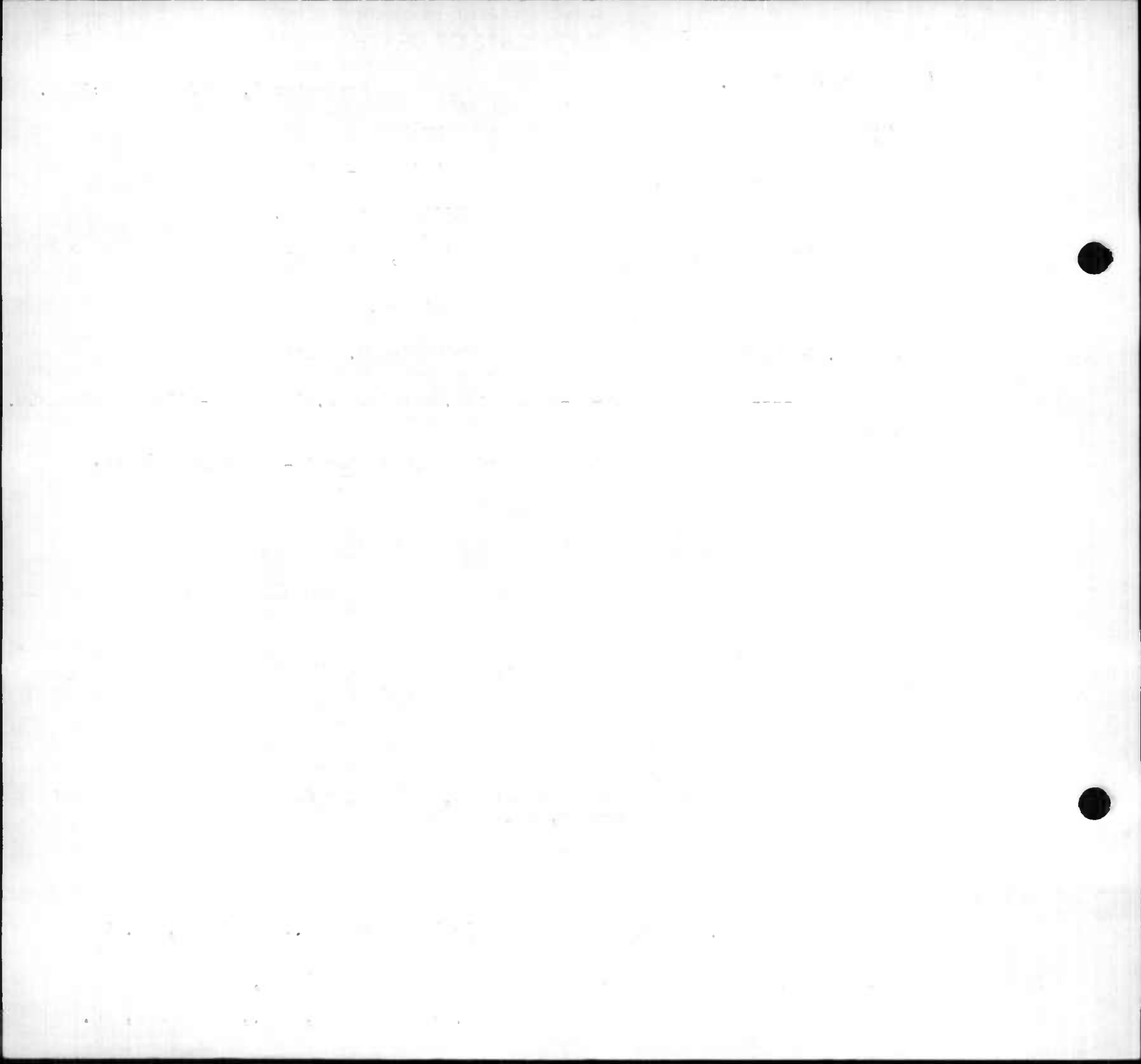
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|---|---------------|--|-------------------------|--|--------------------------------|
| BIRTH NO. 53266 09370 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09370 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Nicholas Pantayas | | 2. DATE AND HOUR OF DEATH 9/13/66 1:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 26-07 D. STREET ADDRESS (If rural, give location) 508. S. Newkirk St. 21224 | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 1/1/90 | 9. AGE (In years last birthday) 76 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker | | 10B. KIND OF BUSINESS OR INDUSTRY steel | | 11. BIRTHPLACE (State or foreign country) Greece | |
| 12. CITIZEN OF WHAT COUNTRY? Greece | | 13. FATHER'S NAME not known | | 14. MOTHER'S MAIDEN NAME not known | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Records: BCN-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.17-159X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ? GI malignancy | | CAUSE OF DEATH (A) unknown ? MI (B) congestive heart failure (C) | | INTERVAL BETWEEN ONSET AND DEATH minutes - hrs. 4 years | |
| 19A. DATE OF OPERATION 2 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (his hospital) attended the deceased from 8/20 19 66 to 9/13 19 66, that (I) (we) last saw the deceased alive on 9/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bruce M. Dow | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland Balto. City Hosps. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/15/66 | | 24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Farkas | |
| 25C. FUNERAL DIRECTOR Nicholas J. Matthews | | ADDRESS 2031 Eastern Ave., Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

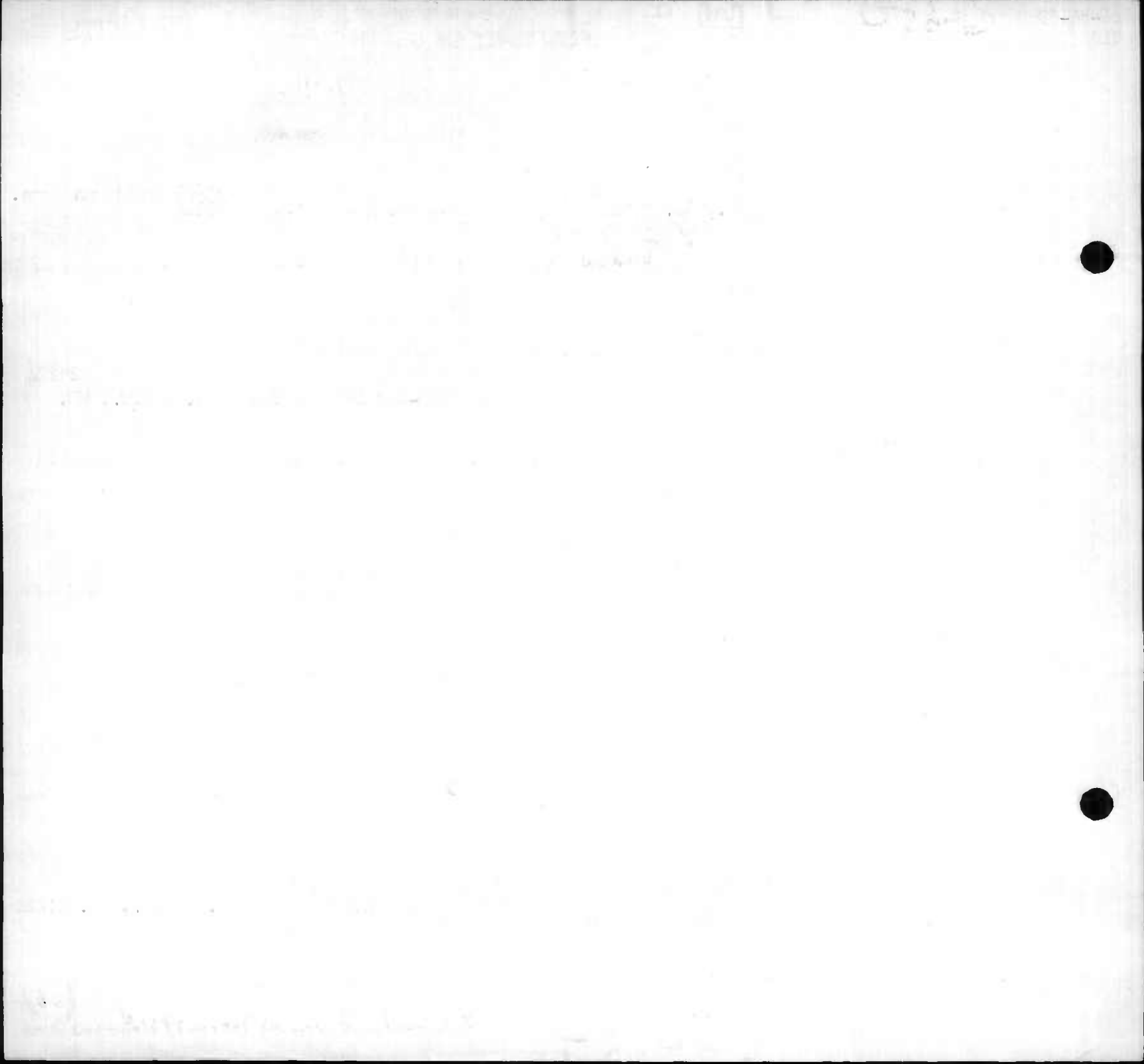
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|---|---|
| 66 09371 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09371 | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Catherine R. Redmond </div> <div> 2. DATE AND HOUR OF DEATH September 3, 1966 2:35 P.M. </div> </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Convalescent Home | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 9-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 21218 D. STREET ADDRESS (If rural, give location) 1331 Homestead St. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH April 14, 1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME John H. Johnson | | |
| 14. MOTHER'S MAIDEN NAME Catherine R. Belle | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-09-4980 | | | 17. INFORMANT ADDRESS Mrs. Genevieve J. Silverberg-1331 Homestead St. | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 2, 1966 to September 1966 , that (I) we last saw the deceased alive on July 2, 9/2 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Clarence W. LeDoux</i> M.D. | | | | 23B. DATE SIGNED 9/6/66 | |
| 23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux | | | | 23D. ADDRESS 3023 Eastern Ave., Baltimore, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/7/66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Clarence W. LeDoux | | 25C. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Baltimore, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09372 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09372 | |
|---|------------------|---|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Emma Mae Green | | | | 2. DATE AND HOUR OF DEATH 9/13/66 10 ⁴⁵ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 EASTERN AVE. Baltimore City Hospitals BALTO., MD. 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. H & S Haven St 21224 | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow | 8. DATE OF BIRTH 9/25/80 | 9. AGE (In years last birthday) 85 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Messenger 217-03-1676 | | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Rider. | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | | |
| 17. INFORMANT RECORDS-BCH 4940 EASTERN AVE. BALTO., MD. | | | ADDRESS 21224 | | 18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION None | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/25 1965 to 9/13 1966, that (I) (we) last saw the deceased alive on 9/13/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Bruce M. Dow | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/13/66 | | |
| 23C. PHYSICIAN'S NAME (Type) Bruce M. Dow | | | 23D. ADDRESS Baltimore City Hospitals. 4940 EASTERN AVE. BALTO., MD. 21224 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-17-1966 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR A. E. Fabela | | 25C. FUNERAL DIRECTOR L. J. Fabela | | ADDRESS (361) 7401 Balair Road | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09373 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09373 | |
|--|--|--|--|--|--|-------------------------|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ANNA MAYRETTA FRANKLIN | | | | 9-15-66 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 10-3-66 | | | | A. STATE B. COUNTY | | | |
| 1255 N. BENTALOU STREET 21216 | | | | MARYLAND | | | |
| 5. SEX FEMALE | | | | 6. RACE WHITE | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | | 8. DATE OF BIRTH 1891 12-6-1890 | | | |
| 9. AGE (In years last birthday) 74 75 | | | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN H. RIEDEMAN, SR. | | | | 14. MOTHER'S MAIDEN NAME ANNIE ZUCKWORTH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. NONE | | | |
| 17. INFORMANT MR. GEORGE A. FRANKLIN, 1255 N. BENTALOU ST. | | | | ADDRESS | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Sept 15 1966, that (I) (we) last saw the deceased alive on July 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John C. Pound | | | | 23B. DATE SIGNED 9/16/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. POUND | | | | 23D. ADDRESS 3325 FREDERICK AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 9-19-66 | | | |
| 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY | | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | | 25B. NAME OF REGISTRAR | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. ADDRESS | | | |
| HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29 | | | | | | | |

John C. Givens

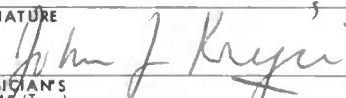
John C. Givens

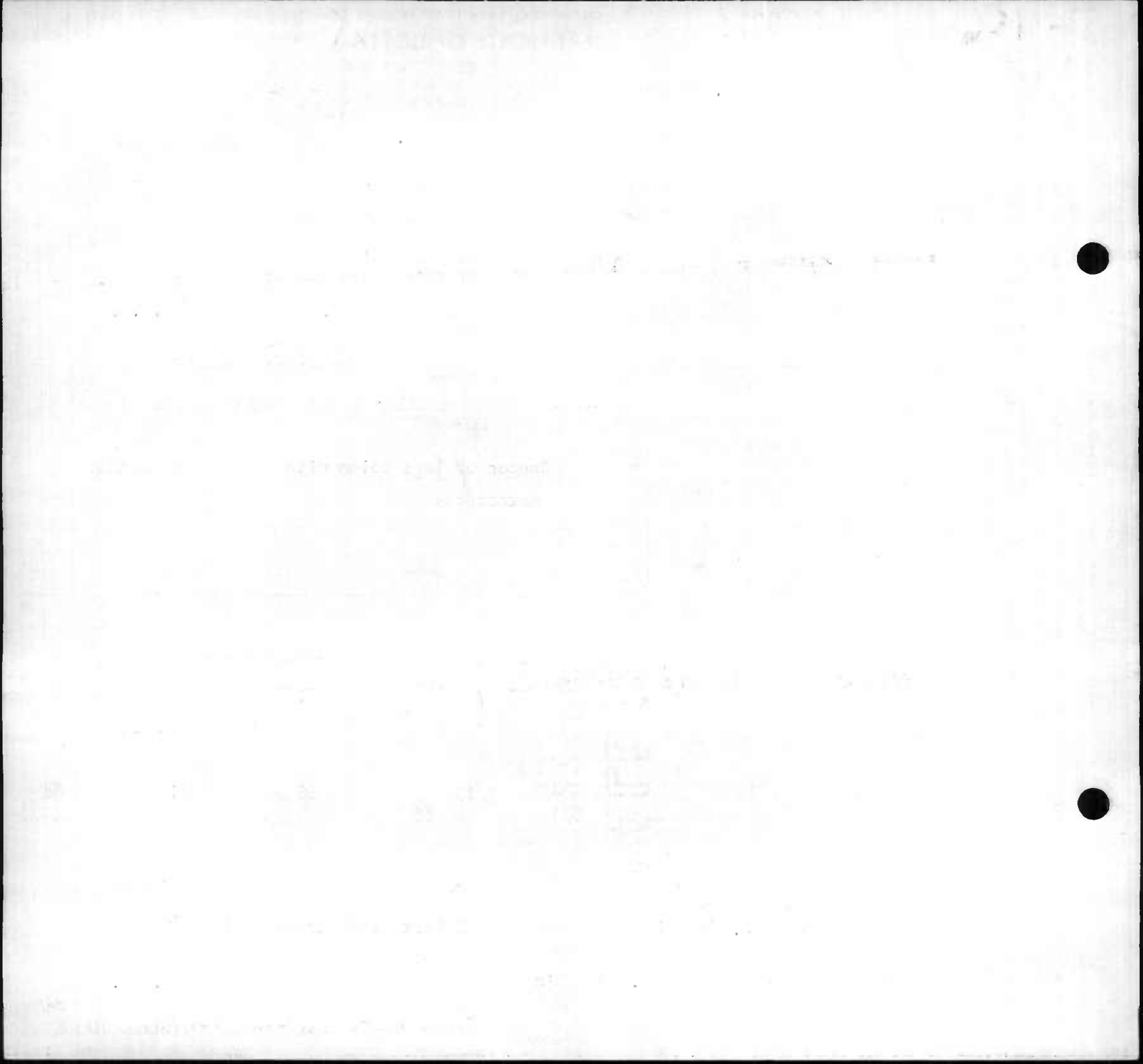
20 - 1966

2/11/11

John C. Givens
John C. Givens

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

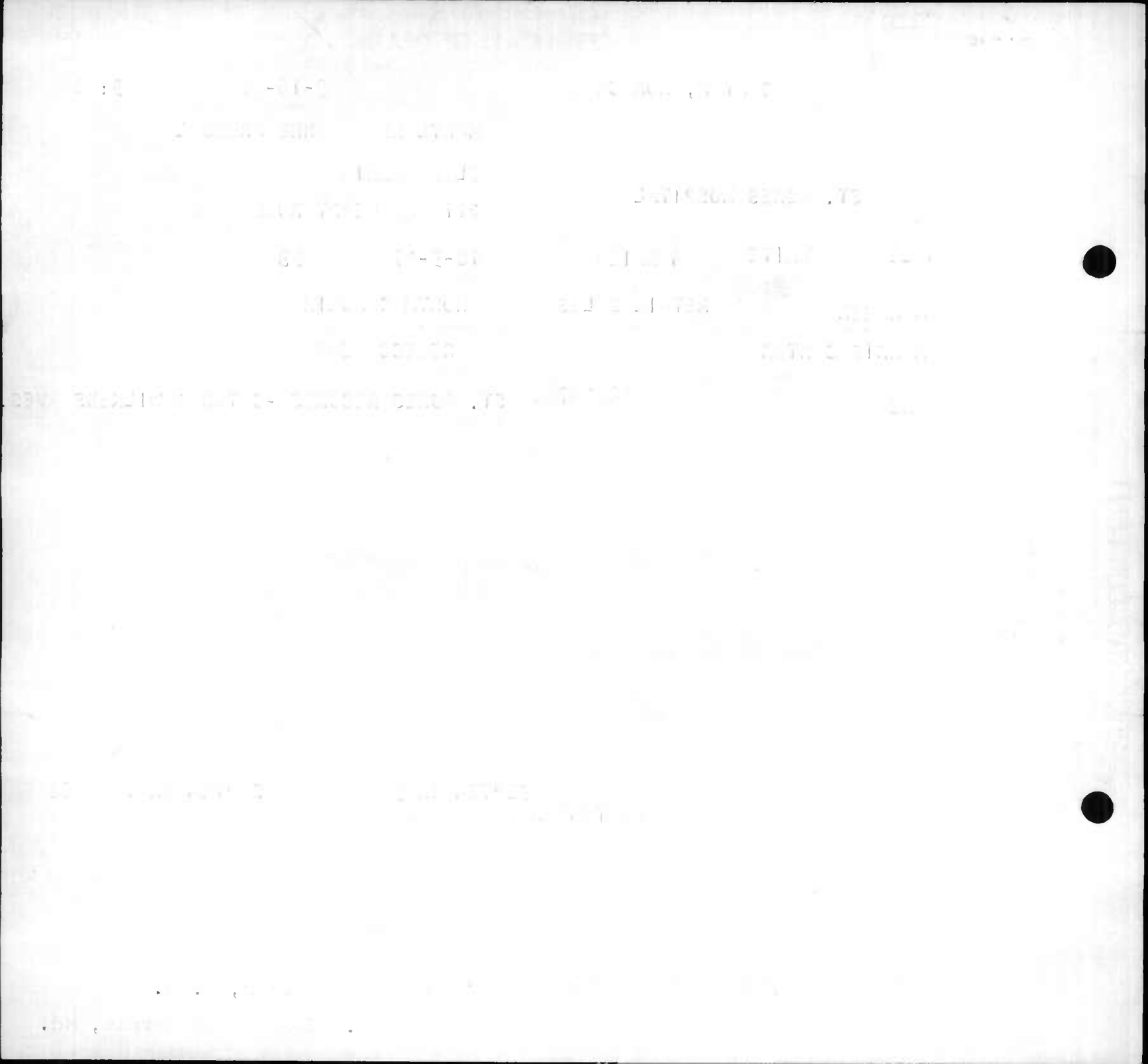
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|---|-------------------------|--|--------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09374 | |
| BIRTH NO. 66 09374 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9-16-1966 M. | |
| 1. NAME OF DECEASED (Type or Print) Ruth M. Plumer | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesorium 6116 Belair Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 53-00 D. STREET ADDRESS (If rural, give location) 4303 Plumer Avenue #36 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7-29-1900 |
| 9. AGE (In years last birthday) 66 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Milchling | | 14. MOTHER'S MAIDEN NAME Elizabeth Reinhardt | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-07-6742B | |
| 17. INFORMANT Miss Mildred Plumer | | ADDRESS #36 4303 Plumer Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer of left colon with metastases | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 7/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cancer of left colon with metastases | |
| 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/13 19 66 to 8/1 19 66 , that (I) (we) last saw the deceased alive on 8/1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE  | | 23B. DATE SIGNED 9/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) John J. Krejci | | 23D. ADDRESS 2 East Read Street #21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-19-1966 | |
| 24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery | | 24D. LOCATION (City, town, or county) (State) Fullerton Balto. Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR Lassaph Funeral Home 7401 Belair Road | | ADDRESS (36) | |



FUNERAL DIRECTOR: IMPORTANT

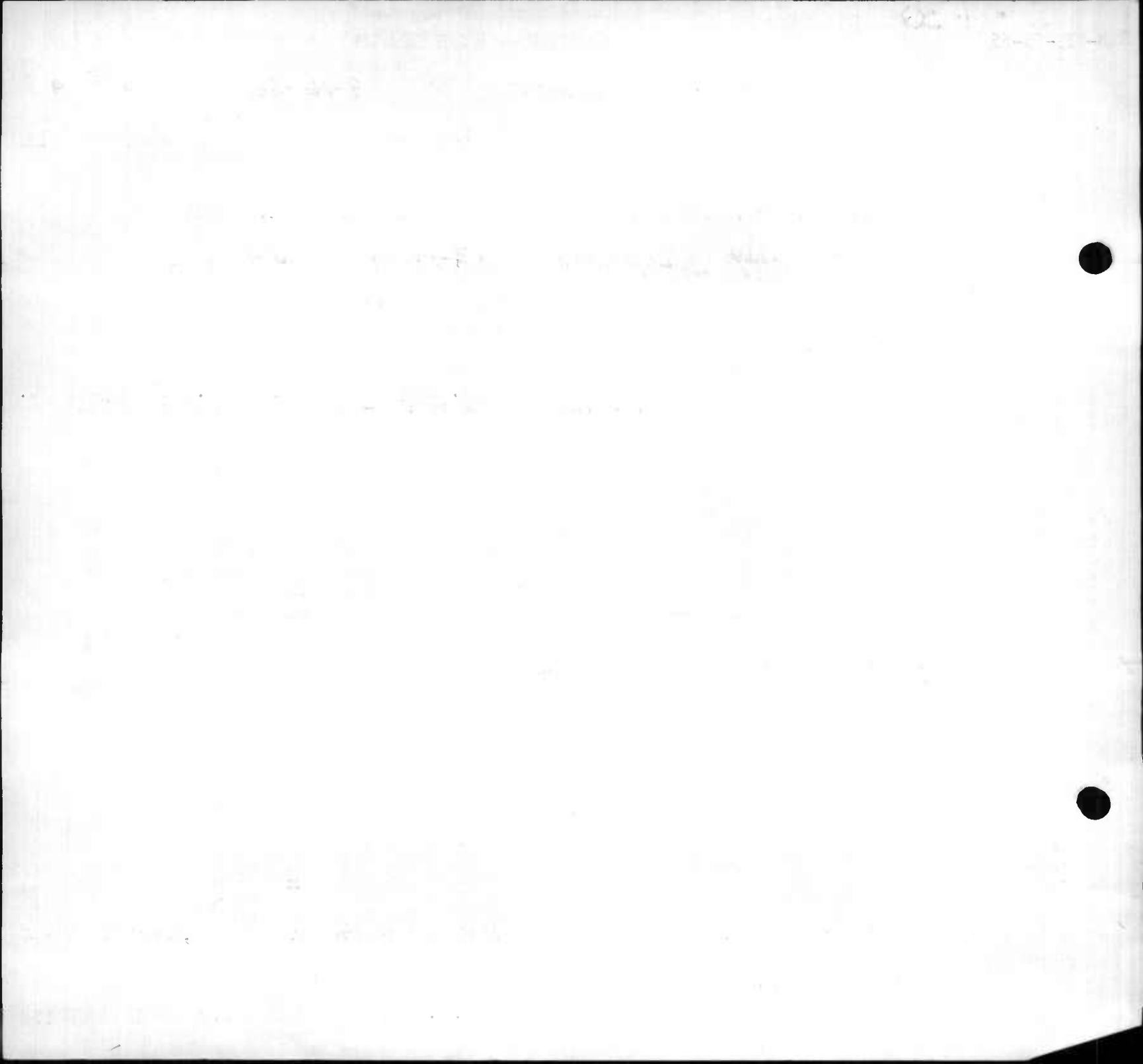
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09375 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09375 | |
|--|-------------------------|--|--|---|--|
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CARTER, HORACE | | | 2. DATE AND HOUR OF DEATH 9-16-66 3:00A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE D. STREET ADDRESS (If rural, give location) 211 AQUAHEART ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10-5-27 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER | | 10B. KIND OF BUSINESS OR INDUSTRY RETAIL SALES | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 13. FATHER'S NAME HARRIS CARTER | | | 14. MOTHER'S MAIDEN NAME REBECCA EDG | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 245247869 | | 17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 446X I Uremia DUE TO nephrosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Terminal Bronchopneumonia | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 3 1966 to SEPTEMBER 16 1966 , that (I) (we) last saw the deceased alive on SEPTEMBER 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Romualdo R. Dator, M.D.</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 16, 1966 |
| 23C. PHYSICIAN'S NAME (Type) Romualdo R. Dator | | | 23D. ADDRESS St. Agnes Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/66 | | 24C. NAME OF CEMETERY or CREMATORY New Hollywood Cemetery | |
| 24D. LOCATION Lumberton, N. C. | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS Raymond C. Fink Glen Burnie, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

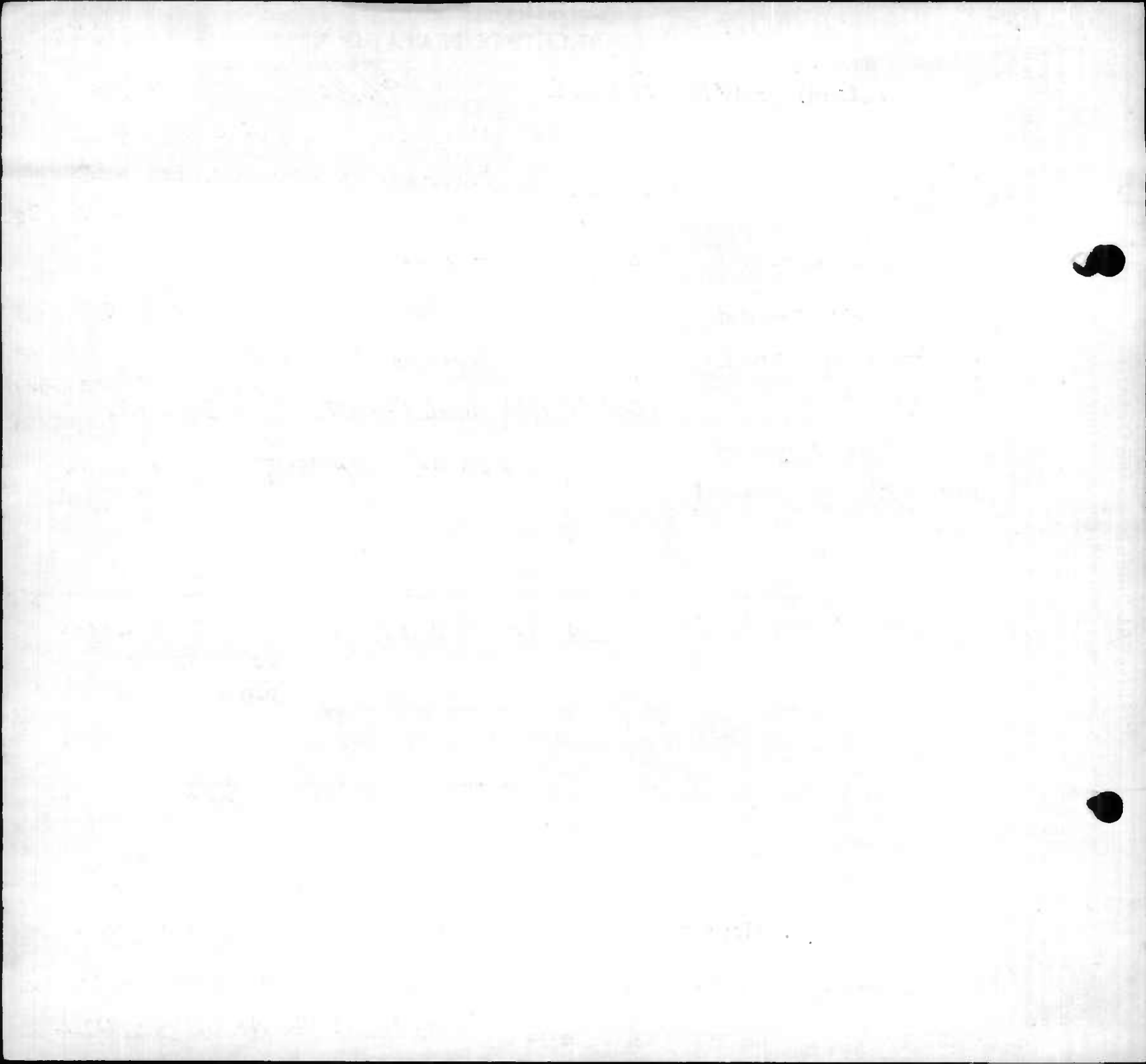
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09376 | |
|---|--|---|---|--|------------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09376 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) HARRY J. ELLIOTT | | | 2. DATE AND HOUR OF DEATH 9-16-66 6²⁰ A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-12 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSP 4940 Eastern Avenue, Baltimore, Maryland | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| D. STREET ADDRESS (If rural, give location) 4901 Eastern Avenue, 21224 | | | 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | |
| 8. DATE OF BIRTH 3-17-07 | | | 9. AGE (In years last birthday) 59 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) MD. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME HARRY ELLIOTT | | | 14. MOTHER'S MAIDEN NAME CATHERINE BRANDT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 216-01-7497 | | |
| 17. INFORMANT ADDRESS Mrs. Frances Roman, 249 S. Washington St. Records: BCM-4940 Eastern Avenue 21224 | | | | | |
| 18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RESP. & CARDIAC ARREST UNKNOWN. | | | INTERVAL BETWEEN ONSET AND DEATH 1 HR. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ESOPHAGEAL CA. | | | | | |
| 19A. DATE OF OPERATION 19-13-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF ESOPHAGUS | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-2-66 19 to 9-16 19 66 , that (I) (we) last saw the deceased alive on 9-16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-16-66 |
| 23C. PHYSICIAN'S NAME (Type) SHIAO-CHIU ANDREW CHEN | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town or village) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09377 | |
|---|---------------------------|---|-----------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09377 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM HENRY POOLE | | 2. DATE AND HOUR OF DEATH 9/11/66 11:05 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | A. STATE MARYLAND B. COUNTY ANNE ARUNDEL | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL - CROWNVILLE P.O. | | | |
| | | D. STREET ADDRESS (If rural, give location) CROWNVILLE P.O. WATERBURY BOX 32 | | | |
| 5. SEX MALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 4/3/60 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR RAILROAD | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME Henry Poole | | 14. MOTHER'S MAIDEN NAME SARAH JOHNSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-05-9992 | | 17. INFORMANT Box 32 - Waterbury Rachel Parrott Crownville P.O. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 161X I | | CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 HOUR | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CA OF LARYNX | | 8 WEEKS | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/9 1966 to 9/11 1966 , that (I) (we) last saw the deceased alive on 9/11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. Clayton | | | | 23B. DATE SIGNED 9/11/66 | |
| 23C. PHYSICIAN'S NAME (Type) M. Clayton | | | | 23D. ADDRESS Univ. Hosp. Balt., MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-15-1966 | | 24C. NAME OF CEMETERY or CREMATORY John Wesley Church | |
| 24D. LOCATION ANNE ARUNDEL CO. MD. | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR C. E. Nicks III | |
| 24J. ADDRESS ANNAPOLIS, MD. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

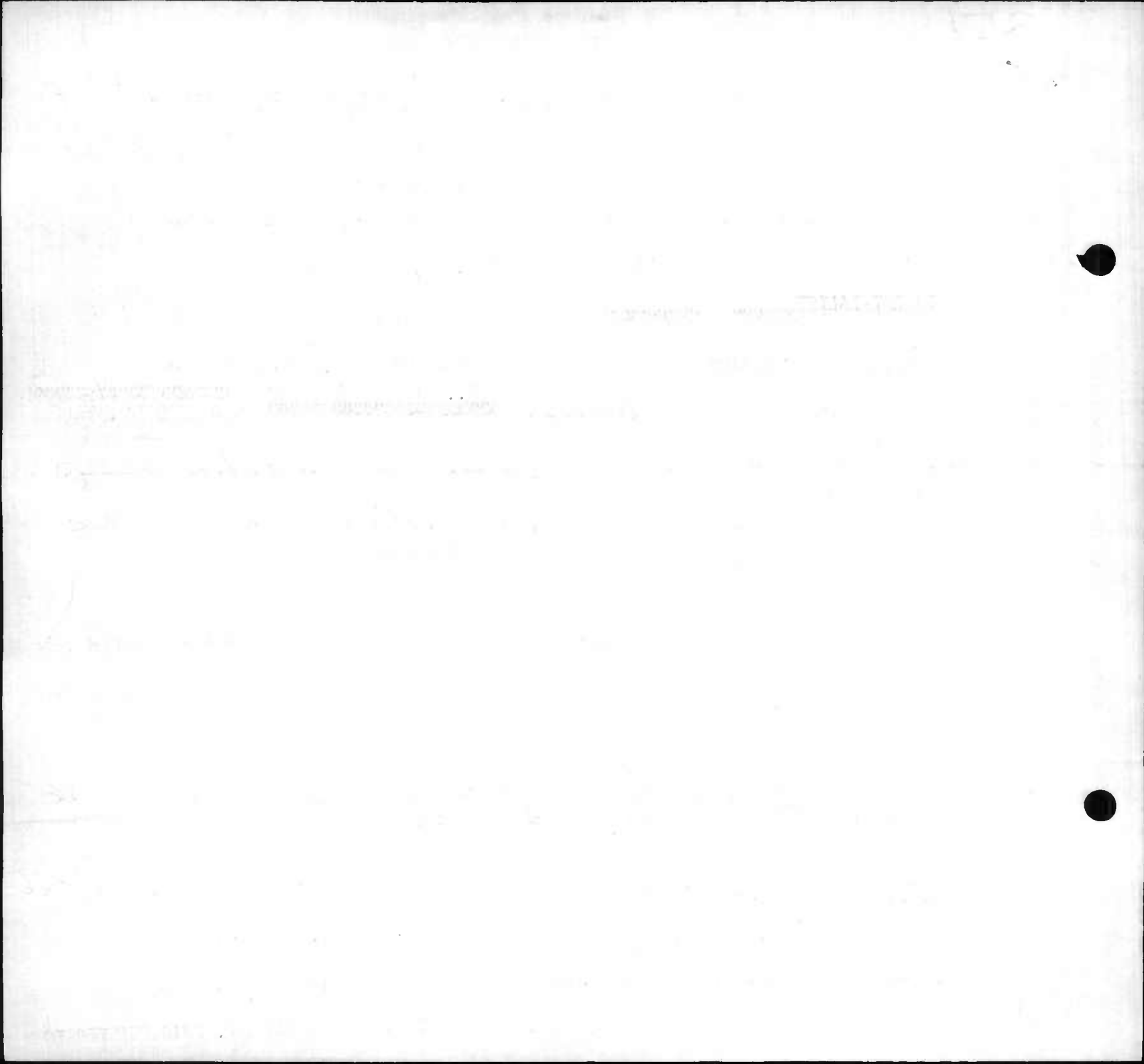
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09378 | |
|--|-----------------------------|--|---|---|---|
| BIRTH NO. 66 09378 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Gussie Schantz</i> | | 2. DATE AND HOUR OF DEATH <i>9/12/66</i> 1:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-19</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>5810 GIST AVE</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED; <input type="checkbox"/> DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH XXXXXXXXXX | 9. AGE (In years lost birthday) <i>80</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>ROMANIA</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>UNKNOWN</i> | | 14. MOTHER'S MAIDEN NAME <i>PAULINE ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NO</i> | | 17. INFORMANT ADDRESS <i>MR. PAUL SCHWARTZ, 5810 GIST AVENUE</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO <i>Coronary Thrombosis</i> (B) DUE TO <i>Hypertension Cardiovascular Disease - years</i> (C) DUE TO <i>Atherosclerosis, Hypertrophic Nephritis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 10 1966</i> to <i>Sept 12 1966</i> , that (I) (we) lost saw the deceased alive on <i>Sept 12 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nathan E. Needle</i> M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/12/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>NATHAN E. NEEDLE</i> M.D. | | 23D. ADDRESS <i>4215 Park Hyb Brome</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>9/14/66</i> | 24C. NAME of CEMETERY or CREMATORY <i>BETH DAVID</i> | | 24D. LOCATION (City, town, or county) (State) <i>ELMONT, LONG ISLAND, NEW YORK</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>SQL LEVINSON & BROS. INC., 6010 REISTERSTOWN</i> | |

FUNERAL DIRECTOR: IMPORTANT

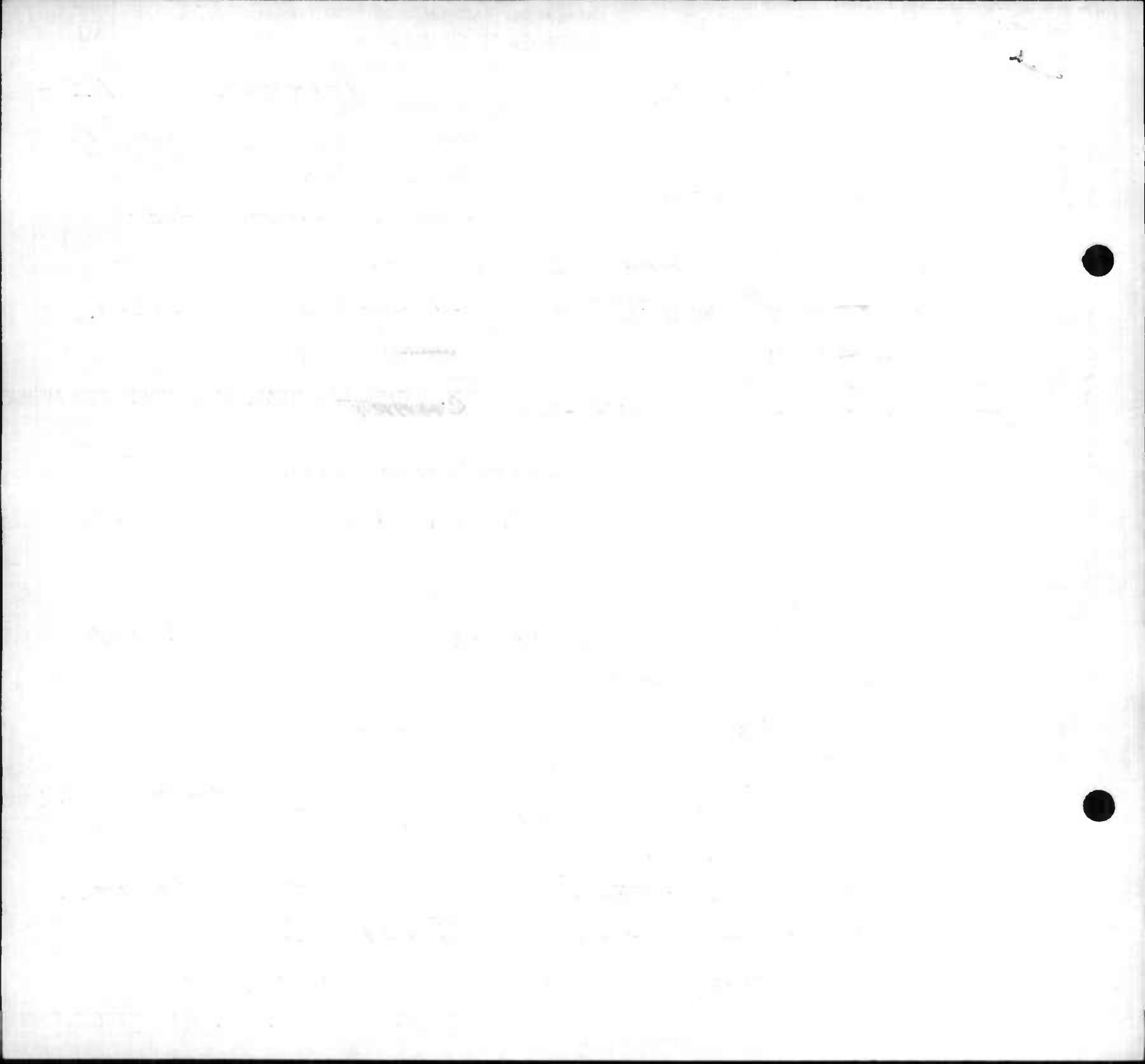
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|----------------------|---|---------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09379 | |
| BIRTH NO. 66 09379 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Rosenbaum, Harvey S. | | 2. DATE AND HOUR OF DEATH Sept. 13, 1966 6:47 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3320 Sequoia Ave. | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH OCT. 14, 1903 |
| 9. AGE (In years lost birthday) 62 | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Issac ROSENBAUM | | 14. MOTHER'S MAIDEN NAME Kate Ornstein | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT MRS. ELOISE ROSENBAUM | | ADDRESS 3320 SEQUOIA AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) DUE TO Myocardial Infarction 3 days (B) DUE TO Arteriosclerotic Heart disease - years (C) _____ | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thoracic trauma during resuscitation 3 days | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 10 19 66 to Sept. 13 19 66 , that (I) (we) last saw the deceased alive on Sept. 13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Erwin H. Hesselberg | | 23B. DATE SIGNED Sept. 13, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Erwin H. Hesselberg | | 23D. ADDRESS Sinai Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/14/66 | |
| 24C. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR P. B. E. Feltman | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. | | ADDRESS 6010 REISTERSTOWN | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|--|
| 66 09380 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09380 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| JACOB ROSENTHAL | | 9-14-66 | | 10:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 42 SINAI HOSPITAL | | BALTIMORE, MD | | 27-20 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 3108 PARKINGTON AVE. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days Hours Min. |
| M | W | MARRIED | 10-1-91 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RUBBER BUSINESS | | WHOLESALE TIRES | | LITHUANIA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| HERTZ ROSENTHAL | | UNKNOWN | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 215-34-1344 | | MRS. ESTHER ROSENTHAL, 3108 PARKINGTON AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 201X-1-260X | | (A) RESPIRATORY ARREST | | 0 | |
| ANTECEDENT CAUSES | | (B) HODGKINS DISEASE | | 2 YRS. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 1 DAY. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | DIABETES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NO | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-2 19 66 to 9-14 19 66, that (I) (we) last saw the deceased alive on 9-14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| [Signature] | | 9-14-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ARTHUR SCHWARTZ | | SINAI HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 9/14/66 | | BNAI ISRAEL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 19 1966 | | [Signature] | | SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09381

BIRTH NO. 66 09381

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Shaw, Maxine

2. DATE AND HOUR OF DEATH

9/13/66 12 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

27-20

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

6810 CROSS COUNTRY BLVD.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MARCH 18, 1918

9. AGE (In years
last birthday)

48

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

KANSAS CITY Missouri

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HERMAN FRIEDSON

14. MOTHER'S MAIDEN NAME

IDA FRIEDSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

UNKNOWN

17. INFORMANT

ADDRESS

RABBI ABRAHAM SHAW, 6810 CROSS COUNTRY BLVD.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

15 mos.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/8/66 19 to 9/13/66 19
that (I) (we) last saw the deceased alive on 9/13 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. L. Young, Jr.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/13/66

23C. PHYSICIAN'S
NAME (Type)

R. L. YOUNG, JR.

M.D.

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

9/14/66

24C. NAME OF CEMETERY or CREMATORY

OHEB SHALOM

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

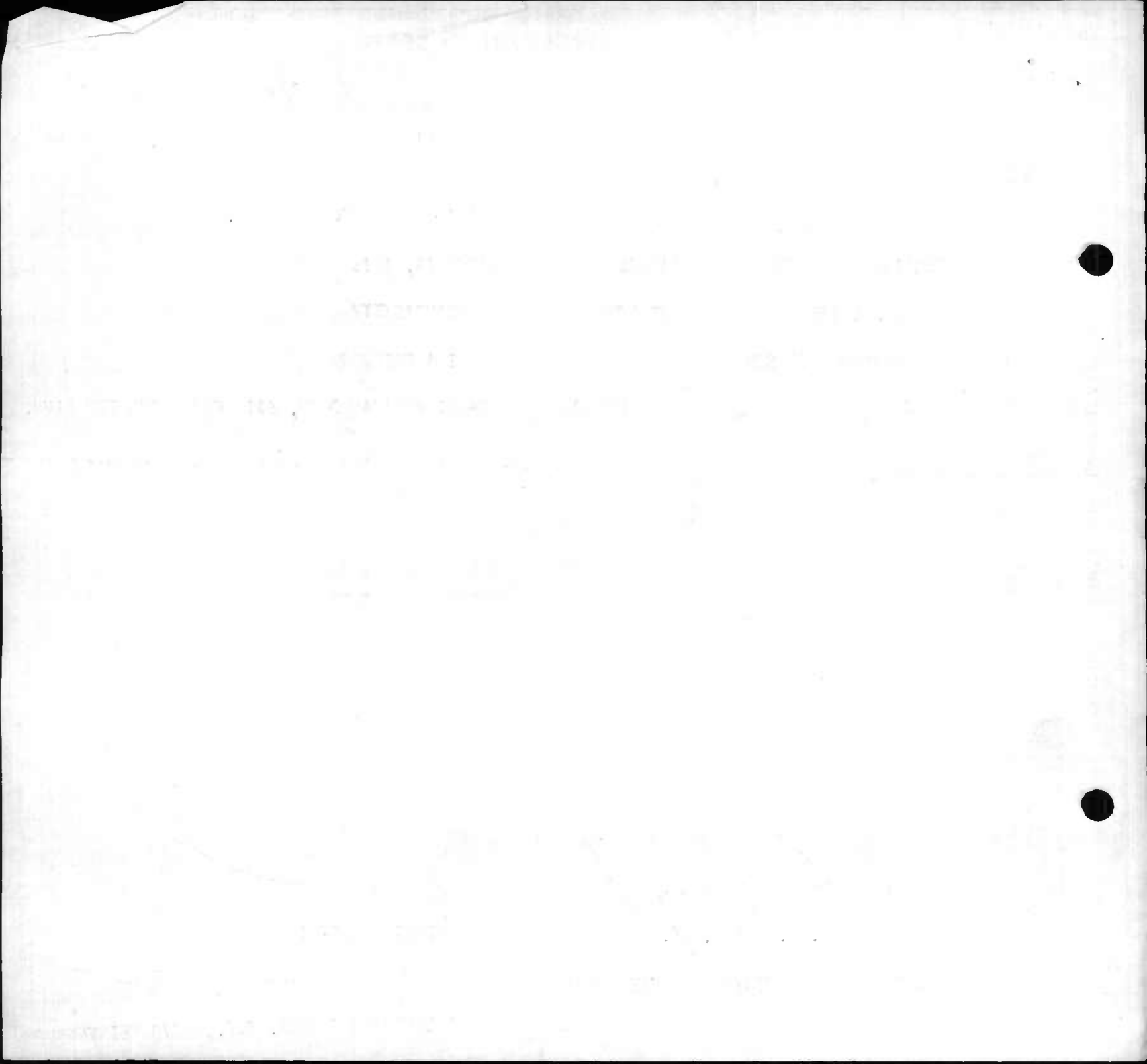
25C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

R. L. Young, Jr.

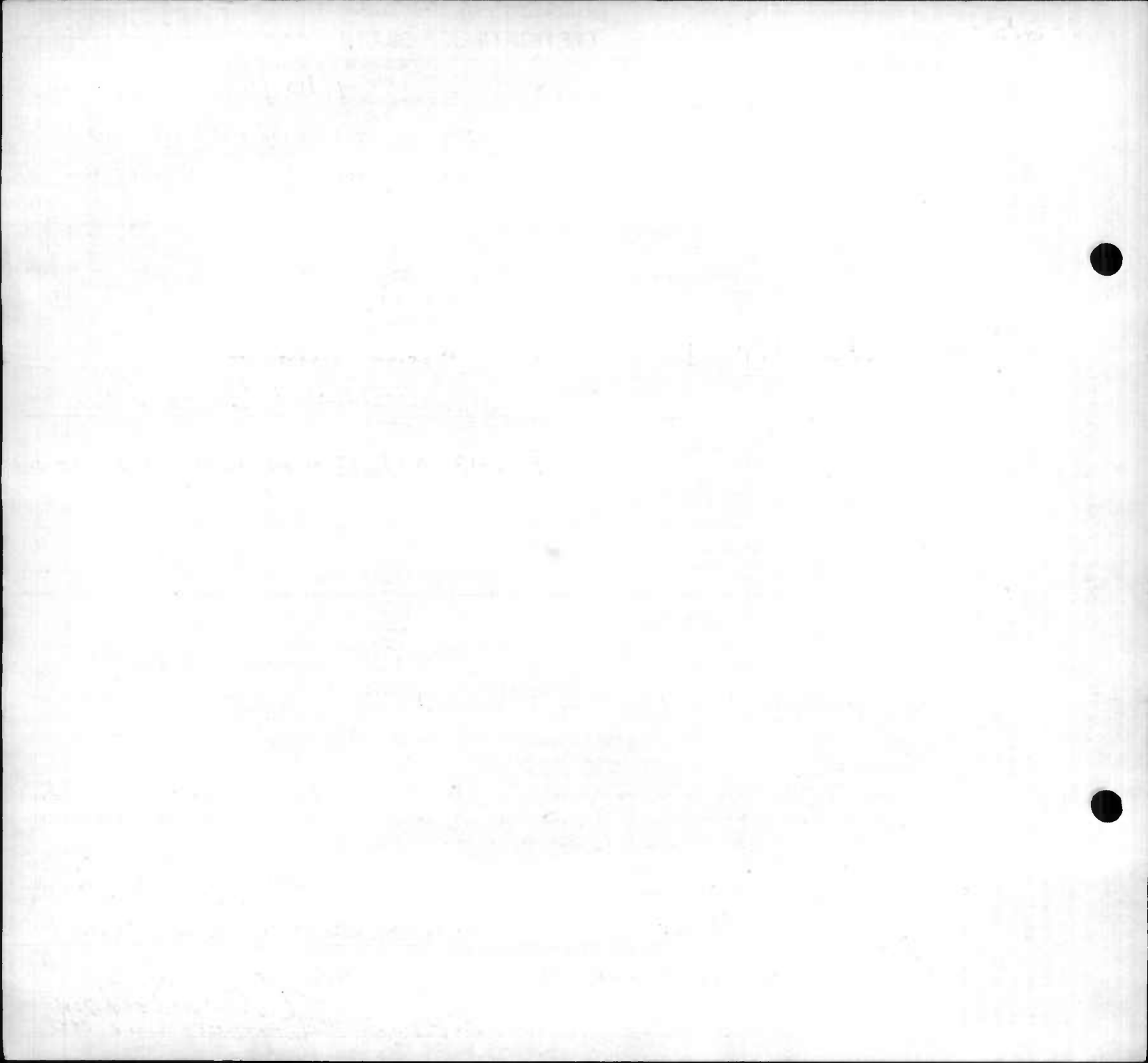
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|------------------------------------|--|--|
| BIRTH NO. 66 09382 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09382 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WASSON BETTY DENNIKOW | | 2. DATE AND HOUR OF DEATH 9/10/66 9:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN CARROLL | | D. STREET ADDRESS (If rural, give location) 56-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY | | (If not in hospital or institution, give street address or location) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH 3/13/14 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) W. VA. | |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME THOMAS WILBURN | | 14. MOTHER'S MAIDEN NAME EMMA WILBURN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT Thomas Wilburn, 18 main ave, Weston, W. Va. | |
| 18. 465 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from 9/8 19 66 to 9/10 19 66 , that (1) (we) last saw the deceased alive on 9/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Kurt Sligar | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/10/66 | |
| 23C. PHYSICIAN'S NAME (Type) Kurt Sligar | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-17-1966 | | 24C. NAME OF CEMETERY or CREMATORY MACHPELAH | |
| 24D. LOCATION (City, town, or county) WESTON (State) W. VA. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR R. E. E. E. E. | |
| 25C. FUNERAL DIRECTOR F. H. H. H. H. | | 25D. ADDRESS ELICOTT CITY MD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 66 09383 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 66 09383 | |
|--|---------------------|---|--|--|---|--|--|------------------------------------|--|
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type in full) MR. CHARLES HERBERT BROCKSMITH | | | | | 2. DATE AND HOUR OF DEATH 9-13-66 10:45 p.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21206 D. STREET ADDRESS (If rural, give location) 6507 BROOK AVENUE | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify) | | 8. DATE OF BIRTH 2-22-28 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN | | 10B. KIND OF BUSINESS OR INDUSTRY CITY DEPT. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME HENRY G. BROCKSMITH | | | | 14. MOTHER'S MAIDEN NAME HILDA E. ROBINSON | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II | | | | 16. SOCIAL SECURITY NO. 211-211-1018 | | 17. INFORMANT WIFE ADDRESS SAME MRS. RACHEL BROCKSMITH | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 277X I CAUSE OF DEATH (A) Acute Myocardial Infarction (Arrest) (B) Suicide: Wound Description (C) Intestinal Obstruction to Electrolyte Imbalance | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 hours 2 days | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Jejuno-Ileal Bypass for Exogenous Obesity | | | | | | | | | |
| 19A. DATE OF OPERATION 8/26/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exogenous Obesity | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT OR UNDERLYING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/22/66 19 to 9/13/66 19 that (I) last last saw the deceased alive on 9/13 1966 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Alan C. Woods Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/13/66 | |
| 23C. PHYSICIAN'S NAME (Type) Alan C. Woods Jr. | | | | | 23D. ADDRESS 550 N. BROADWAY, BALTIMORE, MD. 550 North Broadway, Baltimore 5, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-17-1966 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION Baltimore | | Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR R. G. E. [Signature] | | 25C. FUNERAL DIRECTOR L. [Signature] | | | ADDRESS (34) | | |

W-230

66 09384

BALTIMORE CITY HEALTH DEPARTMENT

66 09384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BLANCHE

E.

WEST

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966

9:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY Wicomico

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Salisbury

D. STREET ADDRESS (If rural, give location)

302 Newton Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 18, 1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Kuehn

14. MOTHER'S MAIDEN NAME

Clara Richel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na ar unknown) (If yes, give wor ar dotes of service)

No

16. SOCIAL
SECURITY NO.

217-22-2025

17. INFORMANT

Clarence West-

ADDRESS

302 Newton St.

Salisbury, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4802 Holder Avenue

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 14 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/16/66

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

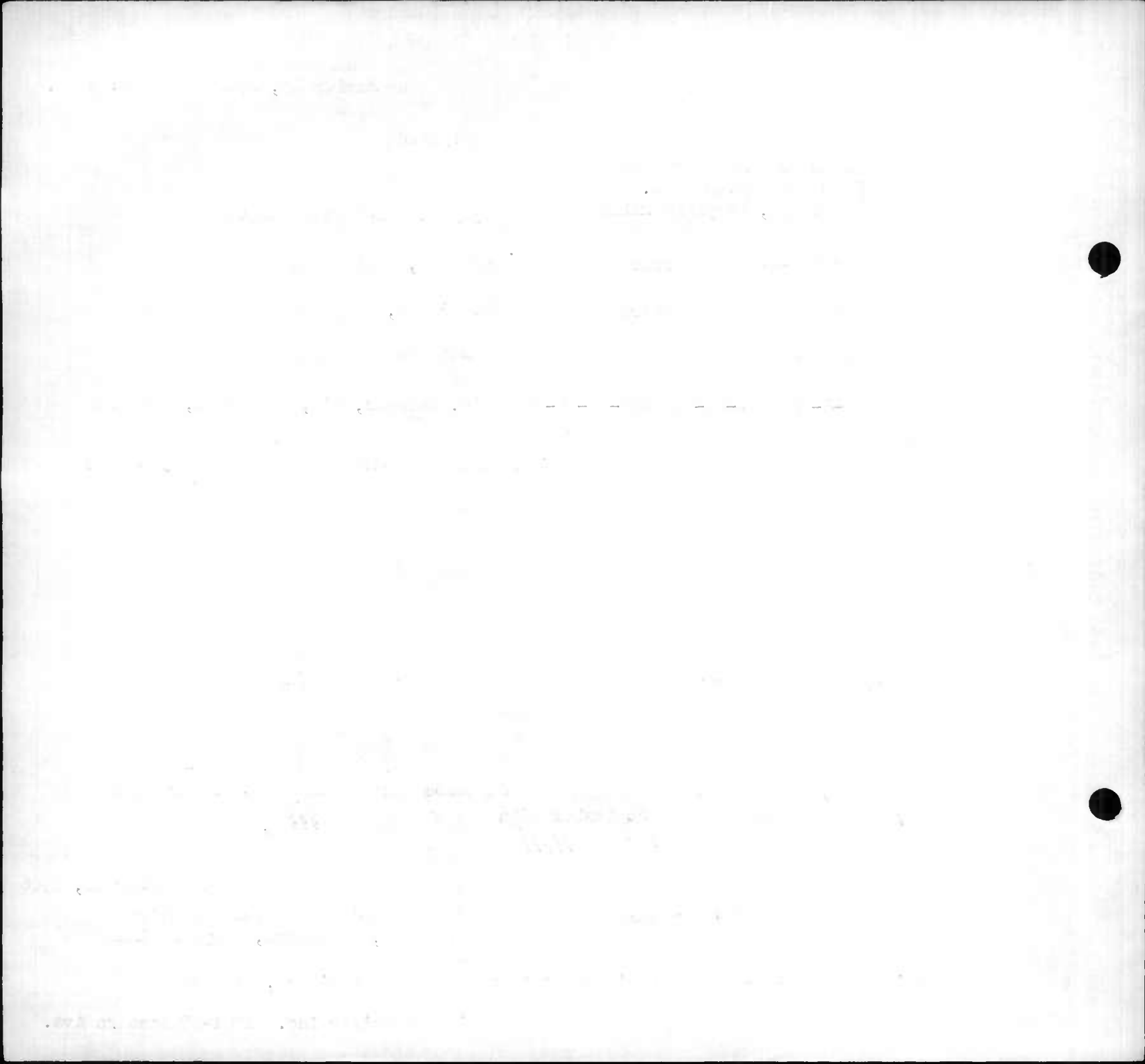
ADDRESS

Robert C. Altenburg-6009 Harford Rd.
Funeral Home, Inc.

WALLINGFORD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

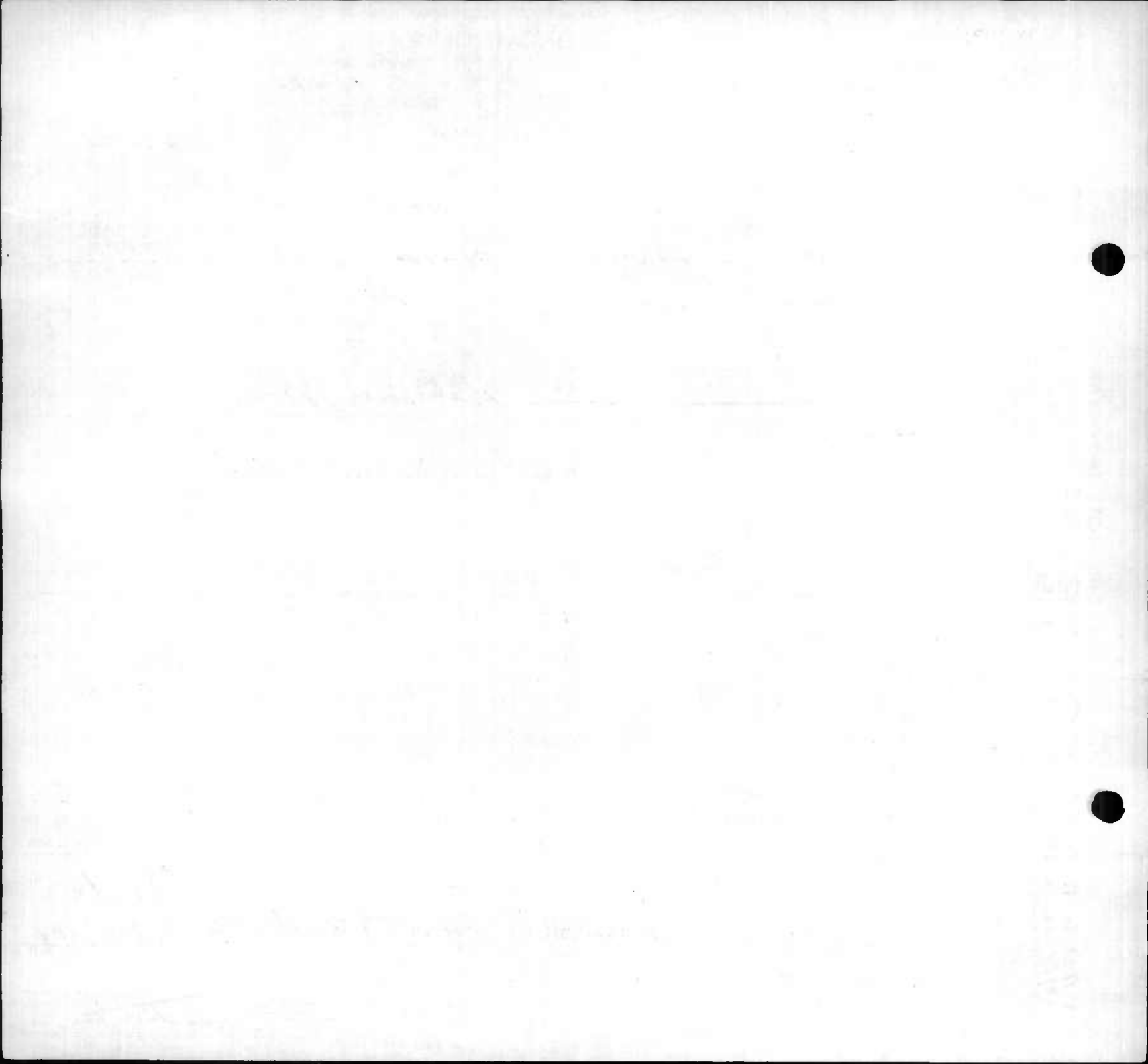
| | | | | | |
|---|--|--|--|--|--|
| 66 09385 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09385 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | EDWARD JAMES PRZYBYSZ | | September 15, 1966 7:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | Maryland 2-01 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Male | | Caucasian | | Married | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| August 1, 1924 | | 42 | | Bartender | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Baltimore, Maryland | | USA | | William Przybysz | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Josephine Mrozinska | | Yes 4-7-43 to 1-19-46 | | 218-12-80-57 | |
| 17. INFORMANT | | ADDRESS | | | |
| Clin. Records, VAH, Baltimore, Maryland | | | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 3 months | | | |
| (A) Cirrhosis of Liver | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 9/14/66 | | Jaundice | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from September 1st 19 66 to September 15th 19 66, that (2) (we) last saw the deceased alive on September 15th 19 66 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | September 16, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DONALD H. HOOKER | | 3900 Loch Raven Boulevard VA Hospital, Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-19-1966 | | Baltimore National | |
| 24D. LOCATION (City, town, or county) | | 24E. FUNERAL DIRECTOR | | | |
| Baltimore, Maryland | | Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. ADDRESS | |
| SEP 19 1966 | | G. E. Taylor, MA | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|---|--|---|--|------------------------------------|--|--|
| BIRTH NO. 66 09386 | | | | | CERTIFICATE OF DEATH | | Registered No. 66 09386 | | |
| 1. NAME OF DECEASED (Type or Print) LUTHER E. TRESLER | | | | | 2. DATE AND HOUR OF DEATH 9/15/66 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3809 KESWICK RD. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 3809 KESWICK RD. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/18/44 | 9. AGE (In years last birthday) 22 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED. | | 11. BIRTHPLACE (State or foreign country) PA. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME ? | | | | | 14. MOTHER'S MAIDEN NAME ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADATRESLER (SAME) | | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) antecedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) antecedent causes DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 19 66 to 9/15 19 66 , that (I) (we) last saw the deceased alive on 9/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Edw. L. Glassman M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/17/66 | | |
| 23C. PHYSICIAN'S NAME (Type) EDWARD L. GLASSMAN M.D. | | | | | 23D. ADDRESS 4037 Falls Rd. Balto. Md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/17/66 | | 24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE | | 24D. LOCATION (City, town, or county) (State) BALTO, MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | 25B. NAME OF REGISTRAR Paul E. Glassman | | 25C. FUNERAL DIRECTOR Paul E. Glassman ADDRESS 3617 Chestnut Ave. | | | | |



B-425

66 09387

BALTIMORE CITY HEALTH DEPARTMENT

66 09387

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARIE

HILDA

(nee EADES)
BLICKENSTAFF

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1966

12:25 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1608 Abbottston Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

1/18/1904

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PRACTICAL NURSE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

EADES

14. MOTHER'S MAIDEN NAME

EMMA KING

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

220/14/8189

17. INFORMANT

227 ST. ARDENNA AVE.
NORMA M. DOELLE, BALTIMORE 21222, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1608 Abbottston Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9

14

'66

P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot in head.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/19/66

23C. NAME of CEMETERY or CREMATORY

CEDAR HILL

23D. LOCATION

(City, town, or county)

(State)

A.A. COUNTY, MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER BROOKS BRADLEY, DUNDALK, MD.

WALLLEY POLICE

PAID BY THE CITY

2000/10/10

2000/10/10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

RUSSELL Henry DOELLE

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1966 12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1608

227 St. Helena Drive Abbottston St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

OCT. 13, 1953

9. AGE (In years
last birthday)

12

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HENRY DOELLE, JR.

14. MOTHER'S MAIDEN NAME

NORMA BLICKENSTAFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

227 ST. HELENA AVE.
NORMA M. DOELLE, BALTO., MD. 21222

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wounds of Neck.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1608 Abbottston Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 14 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot in neck.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/19/66

23C. NAME of CEMETERY or CREMATORY

CEDAR HILL

23D. LOCATION

(City, town, or county)

(State)

A.A. COUNTY, MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER BROOKS BRADLEY, DUNDALK, MD.

SEP 19 1966

1908

1908

1908

1908

1908

1908

1908

FUNERAL DIRECTOR: IMPORTANT

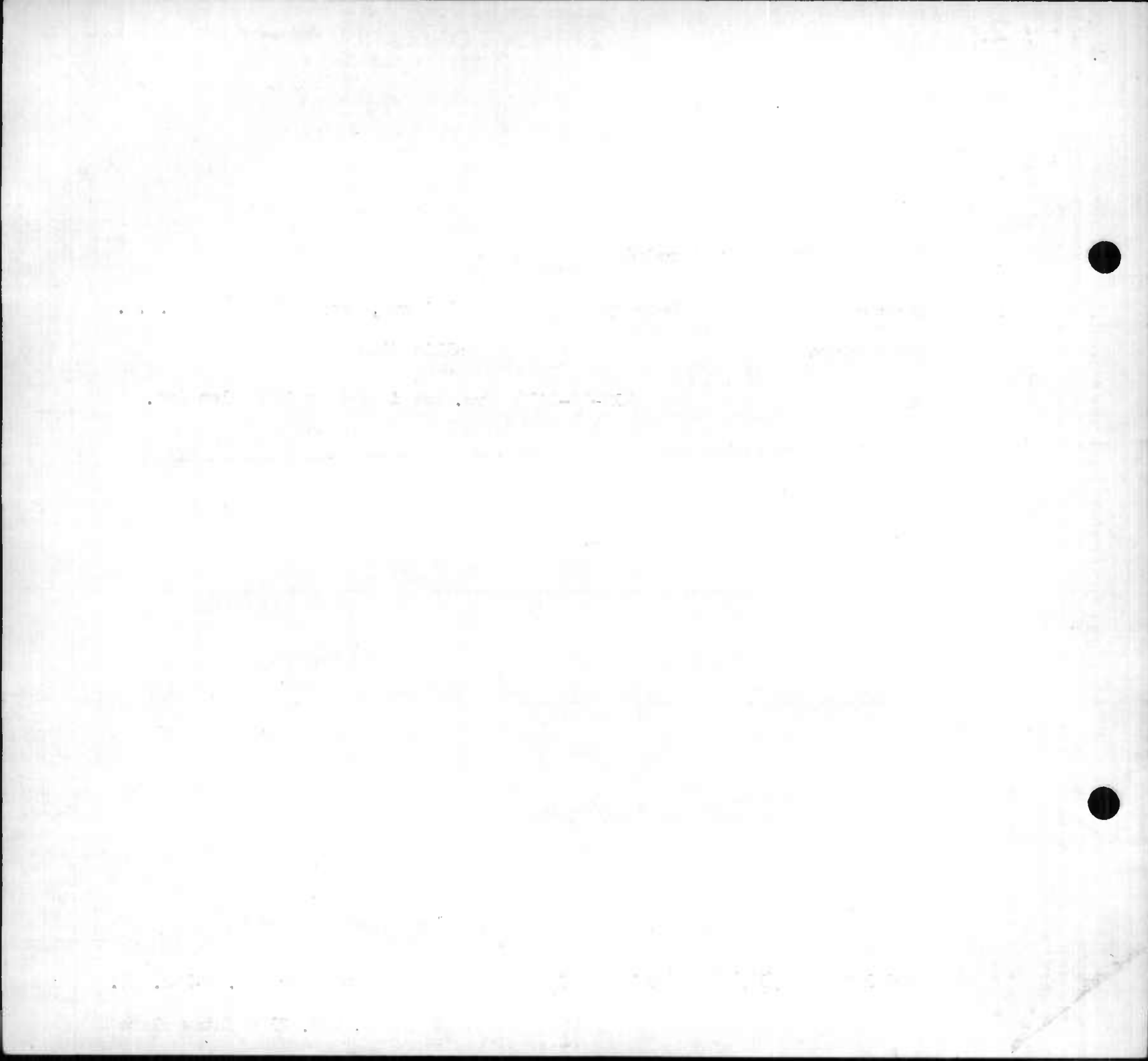
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09389 | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 66 09389 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MYER SOBKOV | | 2. DATE AND HOUR OF DEATH 9/15/66 1:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL | | A. STATE MARYLAND B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3502 GLEN. AVE | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/19/08 | 9. AGE (In years lost birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer | | 10B. KIND OF BUSINESS OR INDUSTRY Grocery | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Hyman Sobkov | | 14. MOTHER'S MAIDEN NAME Mollie Winn | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-26-4436 | | 17. INFORMANT ADDRESS Mrs. Bessie Sobkov 3502 Glen Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cor Pulmonale Pulmonary hypertension Severe Pulmonary Emphysema | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/15/66 19 66 to 9/15/66 19 66 , that (I) (we) lost saw the deceased alive on 9/15/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gerardo Ypil Jr. M.D. | | | | 23B. DATE SIGNED 9/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) GERARDO YPIL JR. M.D. | | | | 23D. ADDRESS SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/66 | | 24C. NAME OF CEMETERY or CREMATORY Bnai Israel | |
| 24D. LOCATION (City, town, or county) (State) Southern Ave. Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR JACK LEWIS, INC. | | 25C. FUNERAL DIRECTOR ADDRESS 2100 Eutaw Place | |

SEP 19 1966

Vol 2, Tab 2

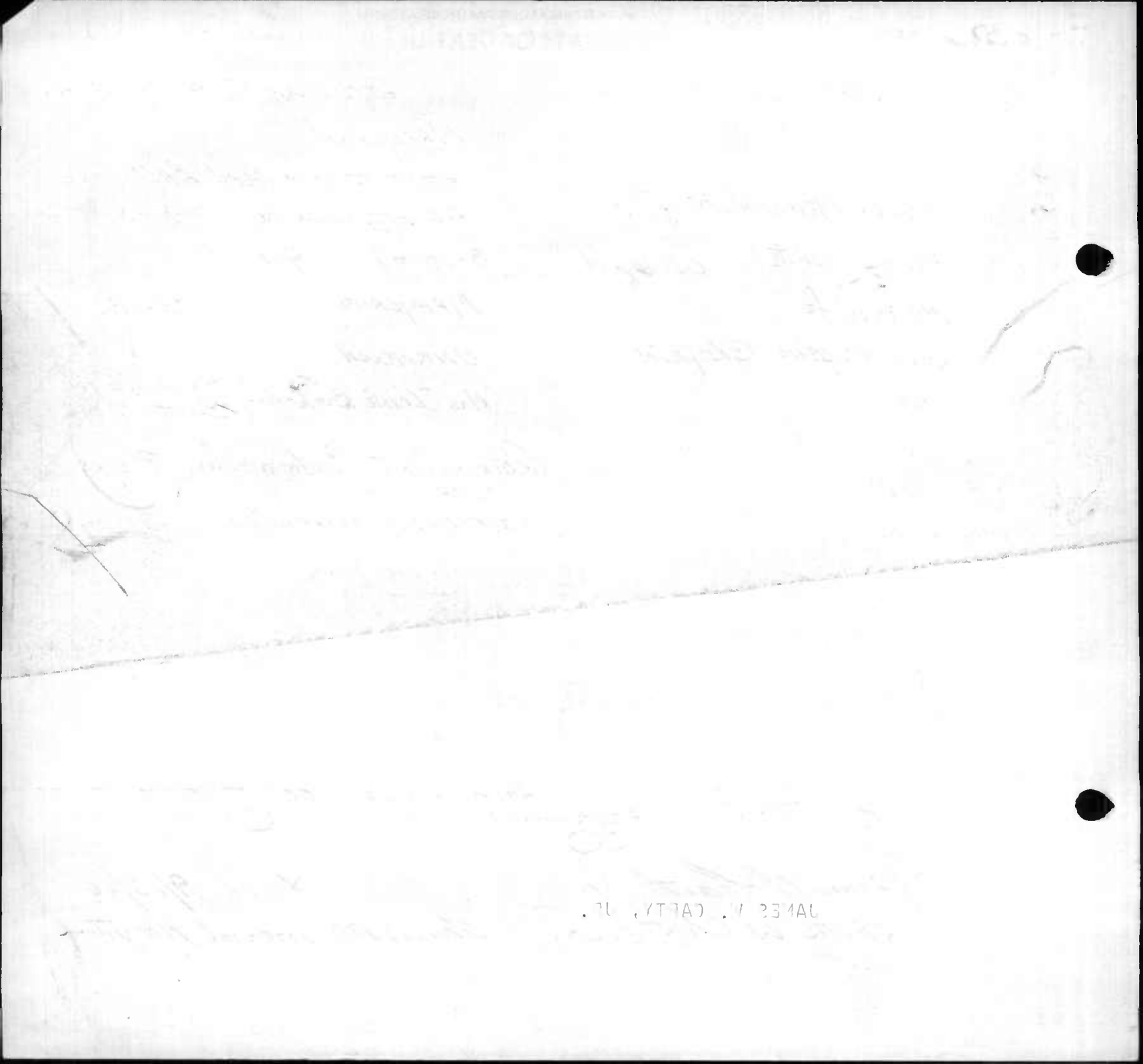
JACK LEWIS, INC. 2100 Eutaw Place



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09390 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09390 | |
|--|--|----------------------------------|--|-------------------------|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>MATILDA FRITSCH</u> | | | 2. DATE AND HOUR OF DEATH <u>September 15, 1966 9:00 A. M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY | | |
| 5. SEX <u>Female</u> | | | 6. DATE OF BIRTH <u>8-18-69</u> | | |
| 7. RACE <u>White</u> | | | 9. AGE (In years last birthday) <u>97</u> | | |
| 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John Kloppein Chopin</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>Mrs. Elaine Buckman</u> | | | ADDRESS <u>3422 Kippel Rd. Balto. 7 Md.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>422.1</u> <u>Atherosclerotic Cardiovascular Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>? yrs.</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) <u>Cerebral Thrombosis</u> <u>3 days</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | | 20A. AUTOPSY? (Yes or No) | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 12, 1966</u> to <u>September 15, 1966</u> , that (I) (we) lost saw the deceased olive on <u>September 15, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>James W. Carty, Jr.</u> | | | 23B. DATE SIGNED <u>9/15/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY, JR.</u> | | | 23D. ADDRESS <u>Union Memorial Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>9/19/66</u> | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | | 25B. NAME OF REGISTRAR <u>John E. Taylor</u> | | |
| 25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> | | | ADDRESS <u>3331 Brehms Lane</u> | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

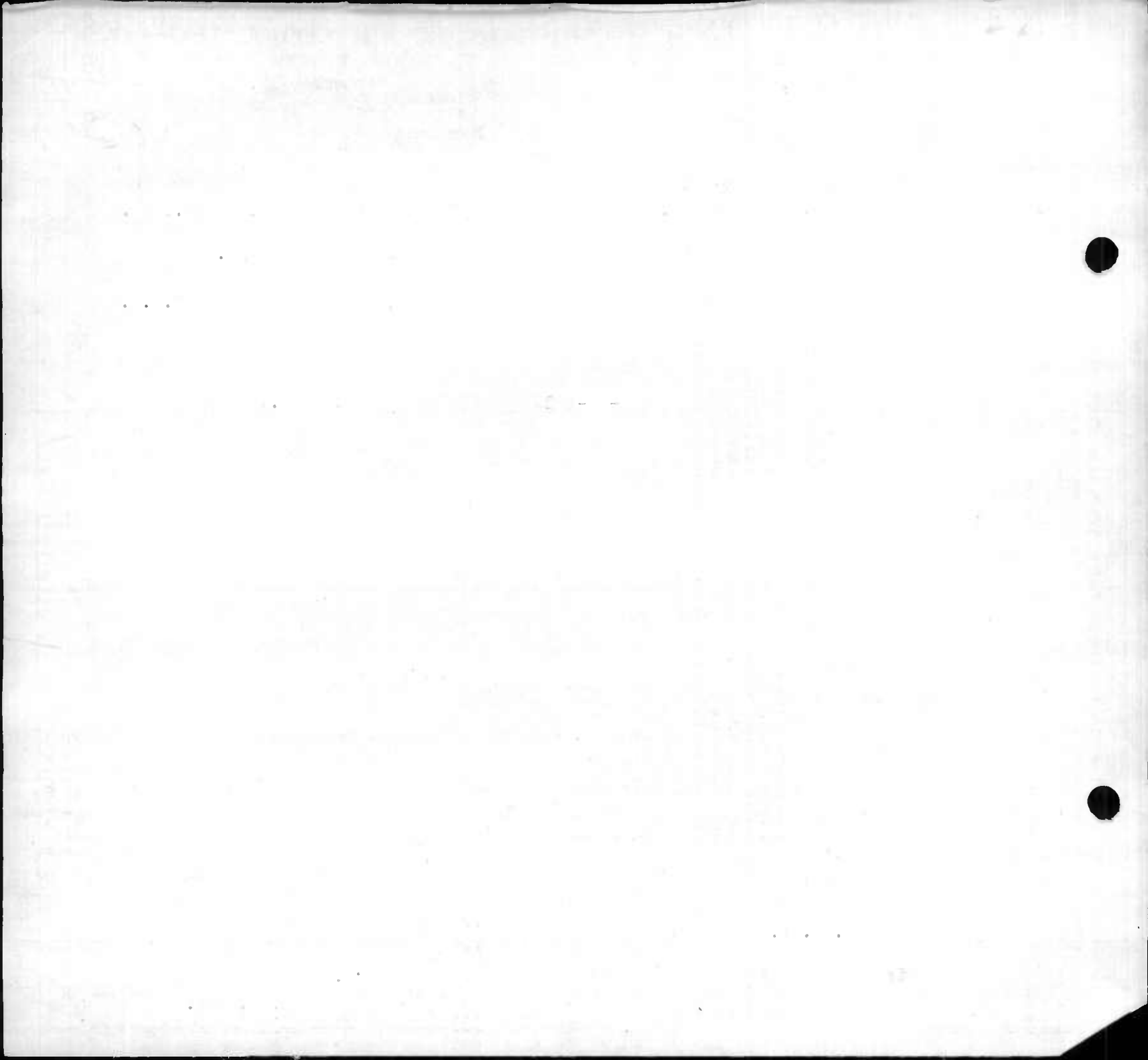
| | | | | | |
|---|---------------|--|------------------------------|---|---|
| BIRTH NO. 66 09391 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09391 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) STEELE, MARIE LOUISE (nee Erdman) | | 2. DATE AND HOUR OF DEATH Sept 14-66 10 35 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 26-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 3902 CHESTERFIELD AVENUE | | | |
| 5. SEX F | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W. | 8. DATE OF BIRTH 01-14-76 | 9. AGE (In years last birthday) 90 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME FRED SEEFELDT (STEPFATHER) | | 14. MOTHER'S MAIDEN NAME BERTHA BIRDMAN/BERGMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 519-10-6148 | | 17. INFORMANT Lenore Devon, neice, above | |
| 18. 4-22-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) congestive heart failure (B) fibrosis of myocardium (C) | | INTERVAL BETWEEN ONSET AND DEATH 4. K. Bm | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12/1966 to 9/14/1966, that (I) (we) last saw the deceased alive on 9/14/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Zoltan Zarday | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) ZOLTAN ZARDAY | | 23D. ADDRESS M.D. Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/66 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |

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FUNERAL DIRECTOR: IMPORTANT

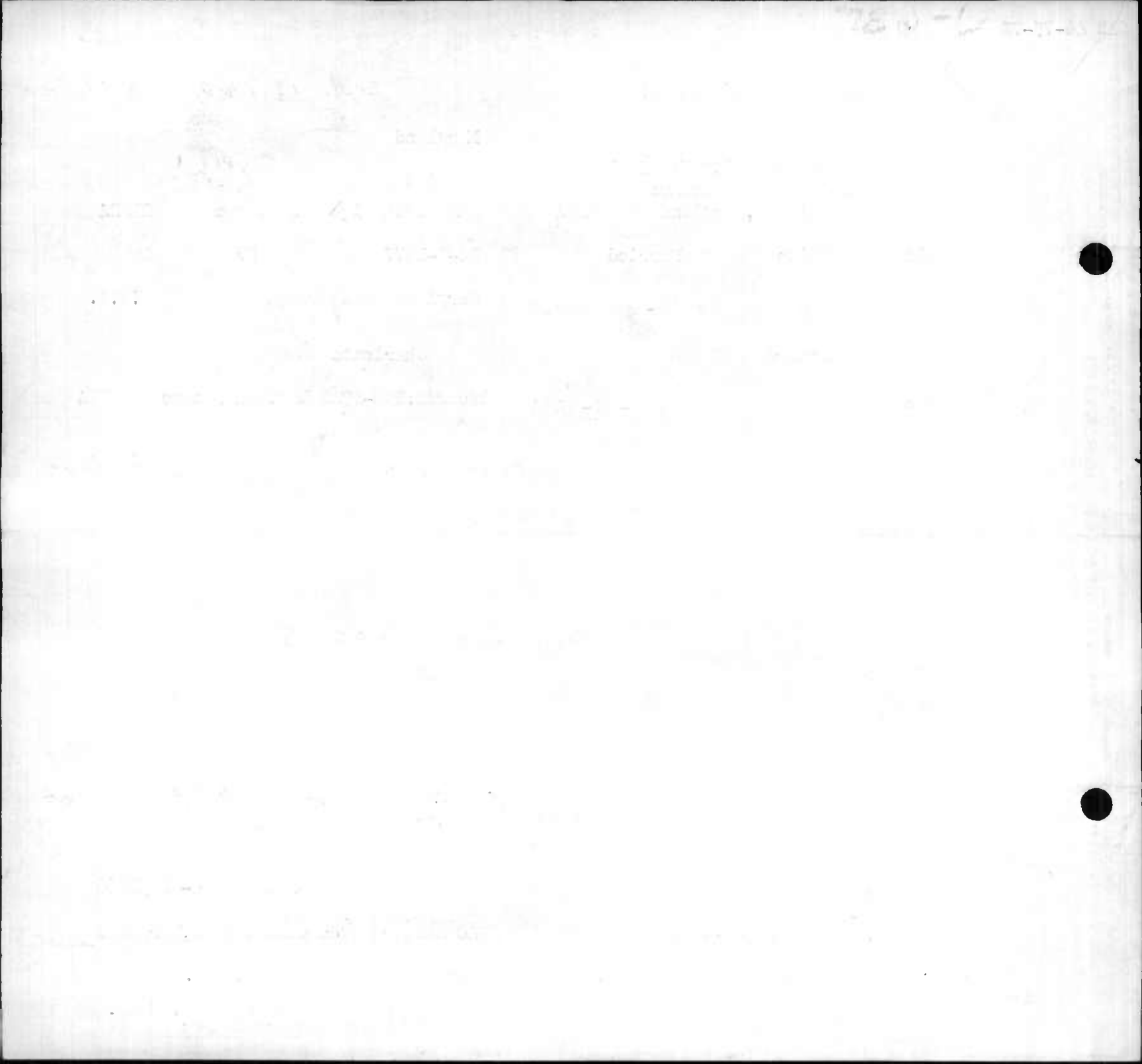
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------------|--|--|--|--|
| 66 09392 | | 66 09392 | | 66 09392 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1. NAME OF DECEASED | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | CLEMENS, LILLY MAY | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | September 14, 1966 4:00 A.M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 3331 McElderry Street Baltimore, Maryland 21205 | | Maryland | | Baltimore | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | |
| female | white | widowed | | 8. DATE OF BIRTH | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) | |
| Housewife | at home | Baltimore, Maryland | | 93 yrs. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Thomas Jefferson Mitchell | | Laura Ringrose | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 217-54-2920 | | Lillian Hayden, dght., above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 10 yrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| none | | none | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| none | | none | | none | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from | | 19 37 to | | Sept 14 1966 | |
| that (I) lost saw the deceased alive on | | 19 66 | | and that in (my) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. A. S. Chalfant | | 6210 York Road | | Sept 15 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. A. S. Chalfant | | 6210 York Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | 9/17/66 | Meadowridge Memorial Park | | Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 19 1966 | Robert E. Fisher, M.D. | Schimunek Funeral Home, Inc. | | ADDRESS | |
| | | 3331 Brehms Lane #13 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 66 09393 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09393 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jordan, Conrad | | 2. DATE AND HOUR OF DEATH Sept. 13, 1966 8:31 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 214 South Highland Avenue 21224 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-2-1877 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer | | 10B. KIND OF BUSINESS OR INDUSTRY self-employed | | 11. BIRTHPLACE (State or foreign country) Maryland Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Leonard Jordan | | 14. MOTHER'S MAIDEN NAME Charlotte Moore | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-30-4191 | | 17. INFORMANT ADDRESS Records: BCM-4940 Eastern Avenue 21224 | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchogenic Carcinoma | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized ASCVD | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 5/30 19 66 to 9/13/ 19 66 , that (H) (we) last saw the deceased alive on 9/13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carl Winterstein M.D. | | | | 23B. DATE SIGNED 9-13/1966 | |
| 23C. PHYSICIAN'S NAME (Type) Carl Winterstein | | 23D. ADDRESS M.D. Baltimore City Hosp. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/66 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Fidler, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



66 09394

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09394

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)JEANETTE W.
JANET W. MOORE

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966 8:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2901 Halcyon Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2901 Halcyon Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

8-27-1894

9. AGE (In years
last birthday)

72 7/8

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED COSMETICS DEPT HUTZLERS DEPT STORE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

WILLIAM HENRY WISNER

14. MOTHER'S MAIDEN NAME

IDA ESTELLE SHIPLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-07-8845

17. INFORMANT

MR. GRADEN L. GREEN 4313 GLENMORE AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 14, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-17-66

23C. NAME of CEMETERY or CREMATORY

DRUID RIDGE

23D. LOCATION

(City, town, or county)

(State)

BALTO., MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

J. Walter Conklin

5444 BELAIR RD.

WALTER B. BIRGE

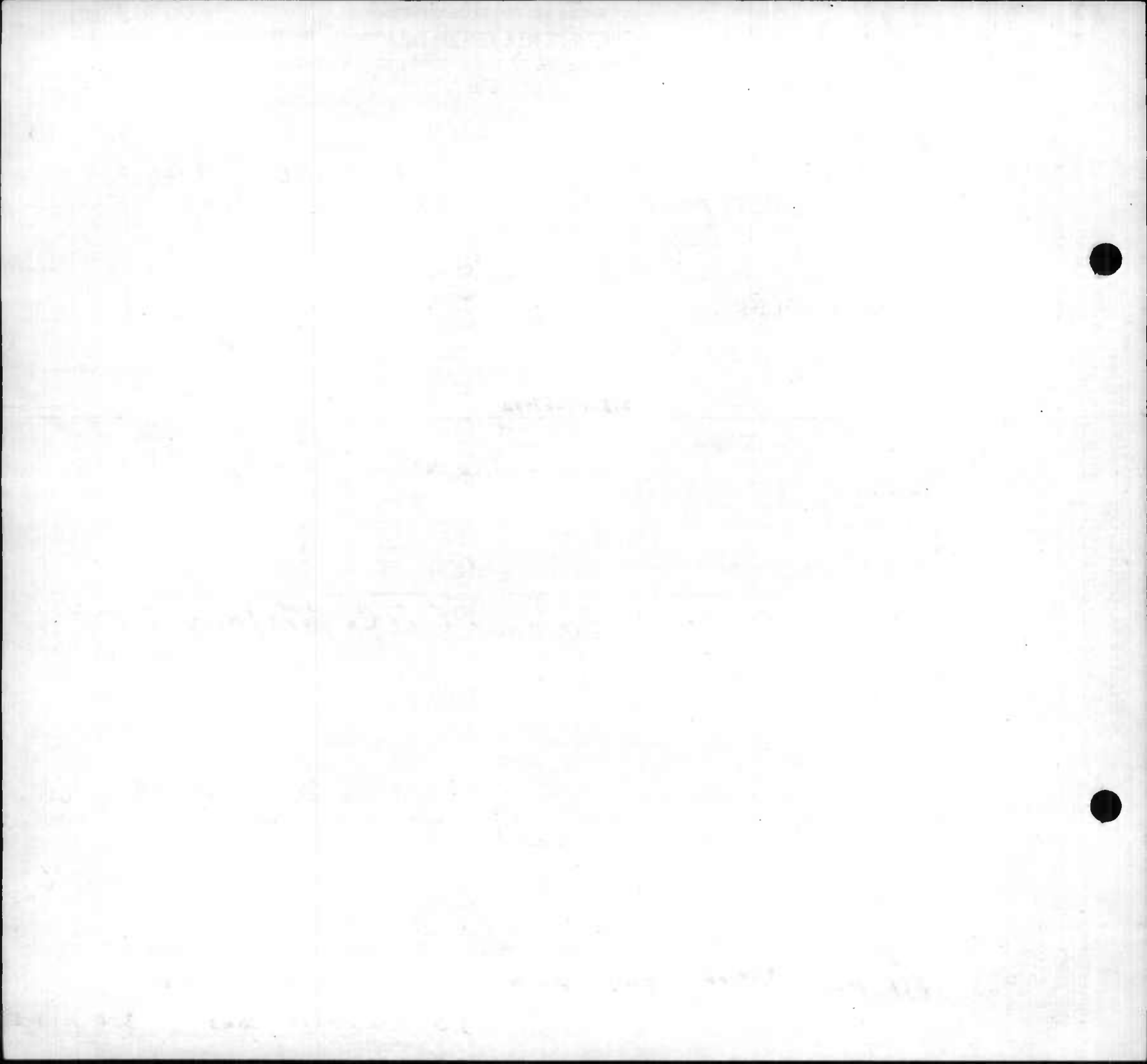
RECEIVED

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

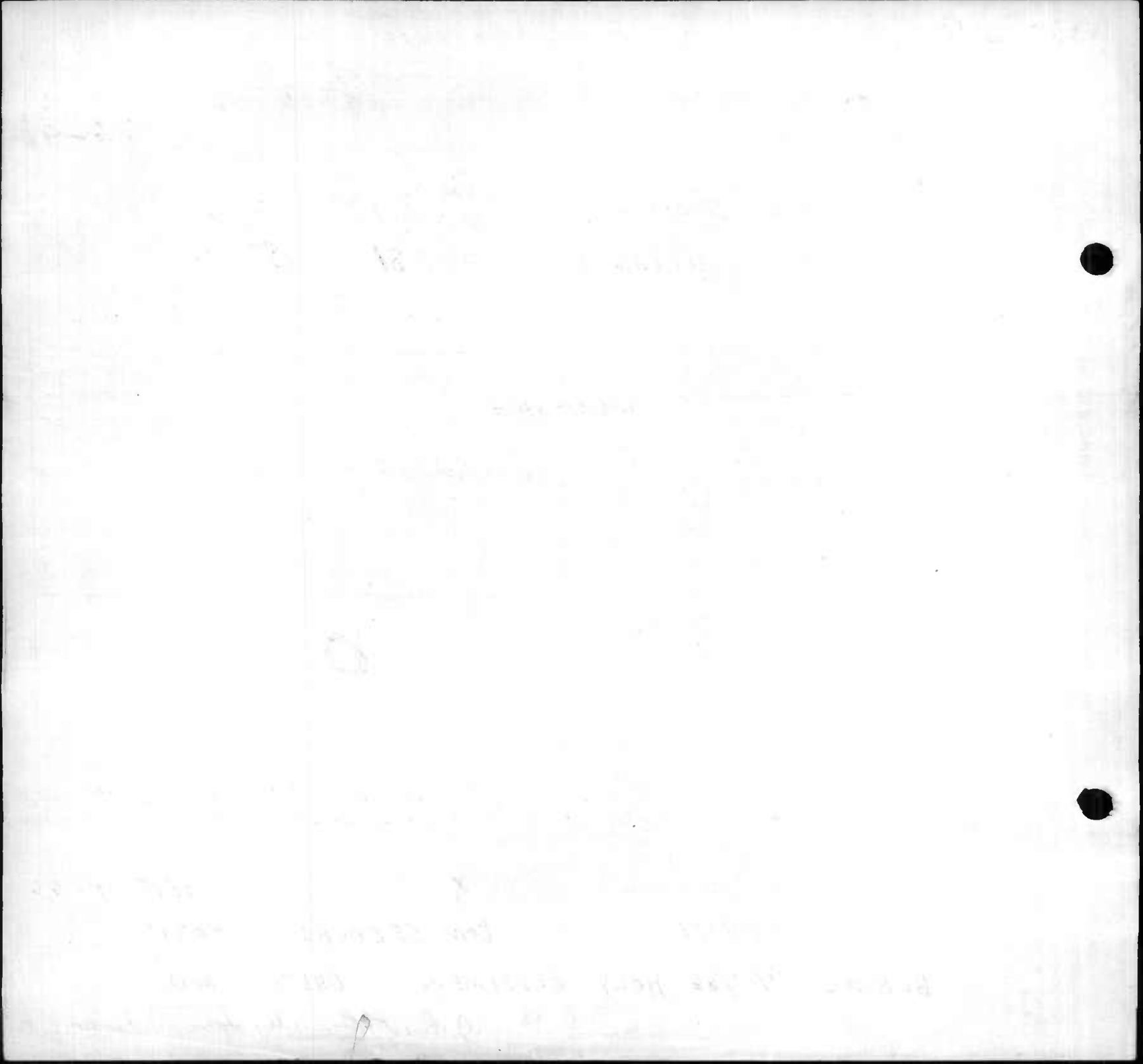
| | | | | | |
|---|------------------|--|-------------------------------------|--|---|
| BIRTH NO. 66 09395 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09395 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. 66 09395 | |
| 1. NAME OF DECEASED (Type or Print) BOMBERG, AUGUST OTTO | | 2. DATE AND HOUR OF DEATH 9-13-66 | | 2 40 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL, BALTIMORE, MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE # 21 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) 200 OAK ROAD | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 10-19-85 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GERMANY | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME BOMBERG, CHEST CHRISTIAN | | 14. MOTHER'S MAIDEN NAME HELEN FISHER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-01-6704A | | 17. INFORMANT ADDRESS | |
| 18. 331X 1143X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Intrauterine Hemorrhage DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SQUAMOUS CELL CA floor of mouth 11 yr. | | | | | |
| 19A. DATE OF OPERATION 9-7-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FLOOR OF MOUTH | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Sept 13 1966 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MD AUGUST 19 1966 to Sept 13 1966 , that (I) (we) last saw the deceased alive on SEPT 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. J. Wizenberg | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 13, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) M. J. WIZENBERG, MD | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/16/66 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION (City, town, or county) (State) BALTO MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Talley | |
| 25C. FUNERAL DIRECTOR J. E. CONNELLY SONS | | ADDRESS 300 MACE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|-----------|--|------------------|---|--|
| 66 09396 | | CERTIFICATE OF DEATH | | 66 09396 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Wade, Henry J | | 9-14-66 3:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| | | Md. 20-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 34 Bon Secours Hospital | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 52 S. Fulton Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | W | Widower | 3/19/84 | 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Wade, Andrew | | Dougherty, Sarah | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 218-03-39524 | | | |
| 18. 331 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Intra venous Kemo- negic (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| D | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 12, 1966 to September 14, 1966, that (I) (we) last saw the deceased alive on September 13, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| J. W. W. W. | | | | SEPT 14-66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SAML BRATHIN | | M.D. BON SECOURS HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | 9/17/66 | HOLY REDEEMER | | BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 19 1966 | | R. E. E. E. E. | | John J. Connelly Sons, 300 Main Ave. | |



WALLER FORT

66 09398

BALTIMORE CITY HEALTH DEPARTMENT

66 09398

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Emma McLean *McLean*

2. DATE AND HOUR PRONOUNCED DEAD

9/15/66 3:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

304 Jack St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W.

8. DATE OF BIRTH

4-23-85

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Richards.

14. MOTHER'S MAIDEN NAME

Adella

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive cardio-
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

9-19-66

23C. NAME OF CEMETERY or CREMATORY

London Park

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

McCully - 237 Patuxent - 25



66 09399

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09399

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY J. ROCHE

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1966 10:00 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1800 Thames Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1800 Thames Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

10-15-40

9. AGE (In years
last birthday)

46

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Augustus.

14. MOTHER'S MAIDEN NAME

Marie Neidenhammer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes.

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL, CREMATION,
REMOVAL (Specify)

23B. DATE

9-20-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat.

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

R. E. Petty

1611 - 237

Patterson - 25

WALTER DORGE

BIRTH NO.

66 09400

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 09400

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LUIGI

D'ALFONSO

2. DATE AND HOUR PRONOUNCED DEAD

September 14, 1966

6:10 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

906 S. Ponca Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

906 S. Ponca Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

March 17-1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tailor *Retired- Tailor Shop

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bucchanico Italy

12. CITIZEN OF
WHAT COUNTRY?

Italy

13. FATHER'S NAME

Camillo D'Alfonso

14. MOTHER'S MAIDEN NAME

Maria Angela ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-01-8151

17. INFORMANT

ADDRESS

Amelia D'Alfonso Wife (906 S. Ponca St.)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Right Pneumonia, Lung Abscess and
~~XXXXXX~~ Empyema.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sep. 19/66

23C. NAME of CEMETERY or CREMATORY

Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

R. E. Farber, M.D.

Sumner Della Noce

322 S. High St.

MATTHEY FORD

1917-18

1918-19

1919-20

1920-21

1921-22

1922-23

1923-24

1924-25

1925-26

1926-27

1927-28

1928-29

1929-30

1930-31

1931-32

1932-33

FUNERAL DIRECTOR: IMPORTANT

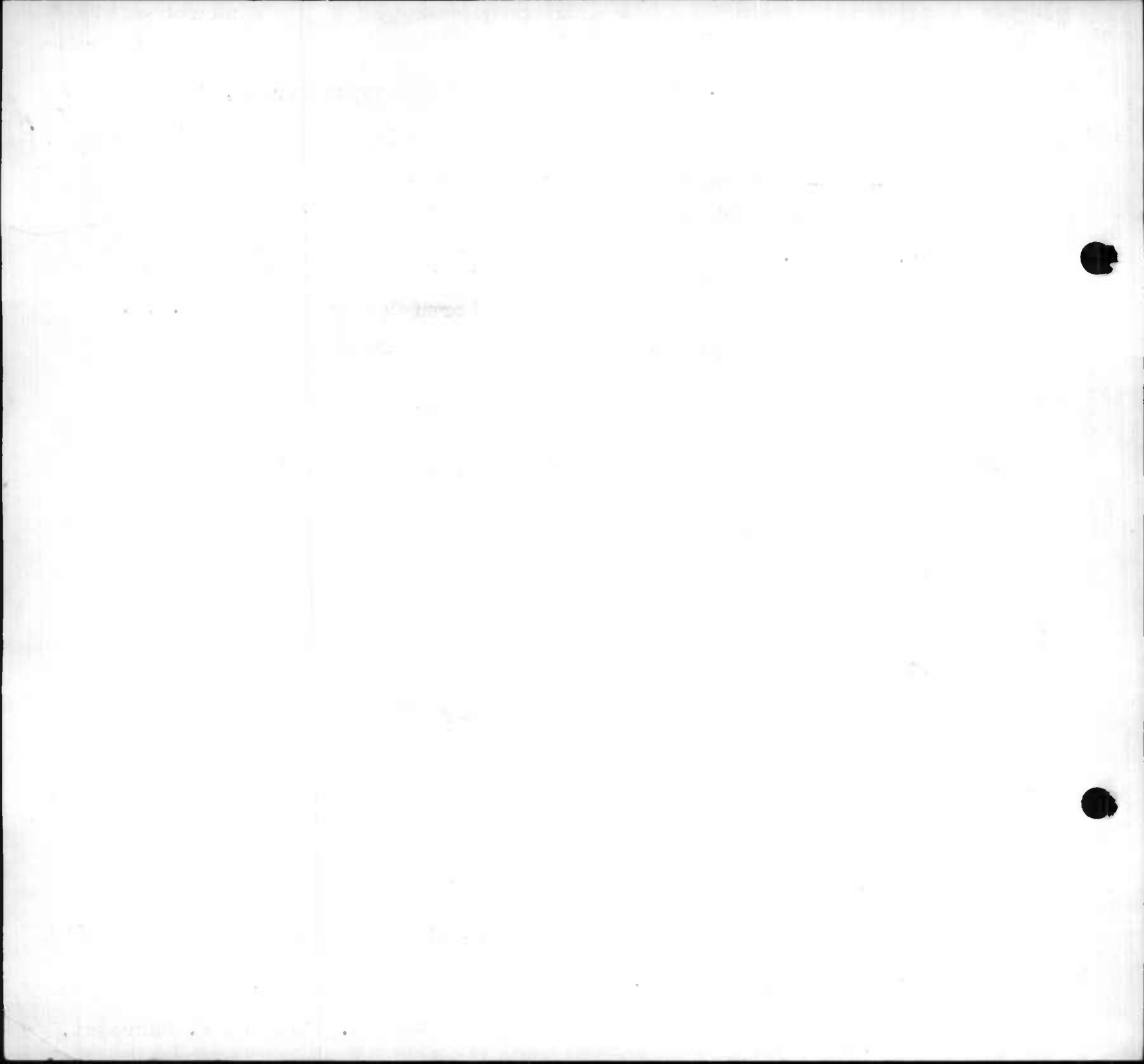
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09401 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09401 | |
|---|-----------------------|--|---------------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) <i>Harry L. Jeffries</i> | | 2. DATE AND HOUR OF DEATH <i>9-12-1966</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-04</i> | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>Provident Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>424 E North Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Col</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>12-13-1903</i> | 9. AGE (In years last birthday) <i>63</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Kentucky</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | 13. FATHER'S NAME <i>William Jeffries</i> | | 14. MOTHER'S MAIDEN NAME <i>Izora</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes War II-1942</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Betty Jeffries 424 E North Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Leukemia</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-25-1956</i> to <i>9-12-1966</i> , that (I) (we) last saw the deceased alive on <i>9-12-1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Percival C. Smith</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9-13-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Percival C. Smith</i> | | 23D. ADDRESS <i>1709 Gwynns Falls Parkway</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-16-66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem Balto</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Rayner Sanders 217 E Preston St</i> | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | | | |

For the Board of Directors
of the Bank of America

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09402 | |
|--|----------------------|---|---|--|--|
| BIRTH NO. 66 09402 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Mary D. Brown | | | 2. DATE AND HOUR OF DEATH September 16, 1966 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bar- Wil- Ba Convalescent Home 2101 W1 Cold Spring La | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2801 Rayner Ave | | |
| 5. SEX F. | 6. RACE C. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 2/28/82 | 9. AGE (In years last birthday) 84 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Unknown Richard Amos | | |
| 14. MOTHER'S MAIDEN NAME Unknown Victoria | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Records | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 9-17- 1963 to 9-16- 1966 , that (I) (we) last saw the deceased alive on 9-14- 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE C.R. Campbell | | | 23B. DATE SIGNED 9-16-66 | | |
| 23C. PHYSICIAN'S NAME (Type) C.R. Campbell | | | 23D. ADDRESS 1618 W. North Ave. Baltimore Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/66 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary | |
| 24D. LOCATION (City, town, or county) Brooklyn, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | |
| 25B. NAME OF REGISTRAR E. Farley | | 25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St. | | | |



66 09403

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09403

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Luebertha Roberta Collins

2. DATE AND HOUR PRONOUNCED DEAD

9/16/66 12:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

538 Laurens St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/21/16

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Vergil Collins 538 Laurens St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/20/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

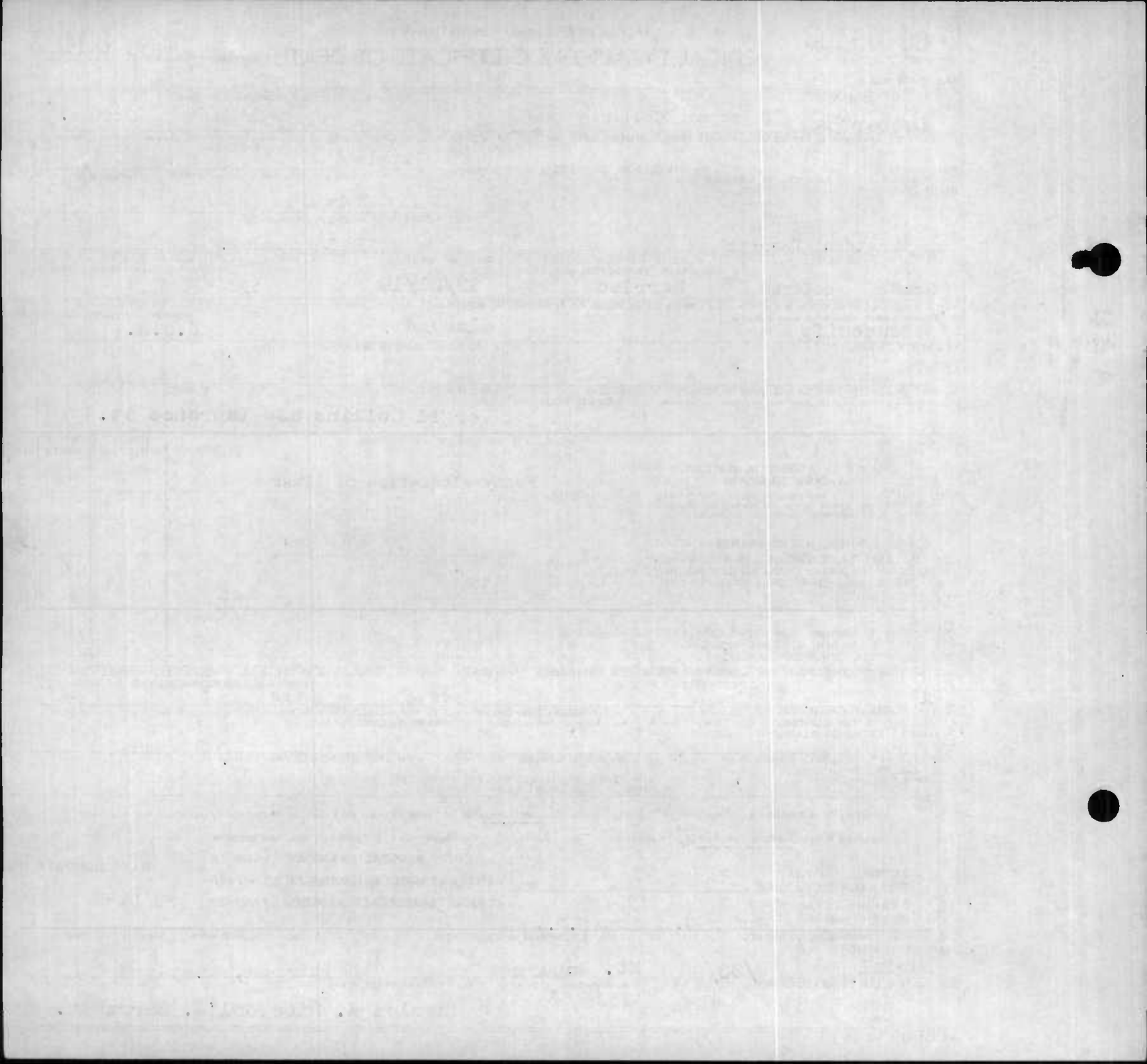
24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

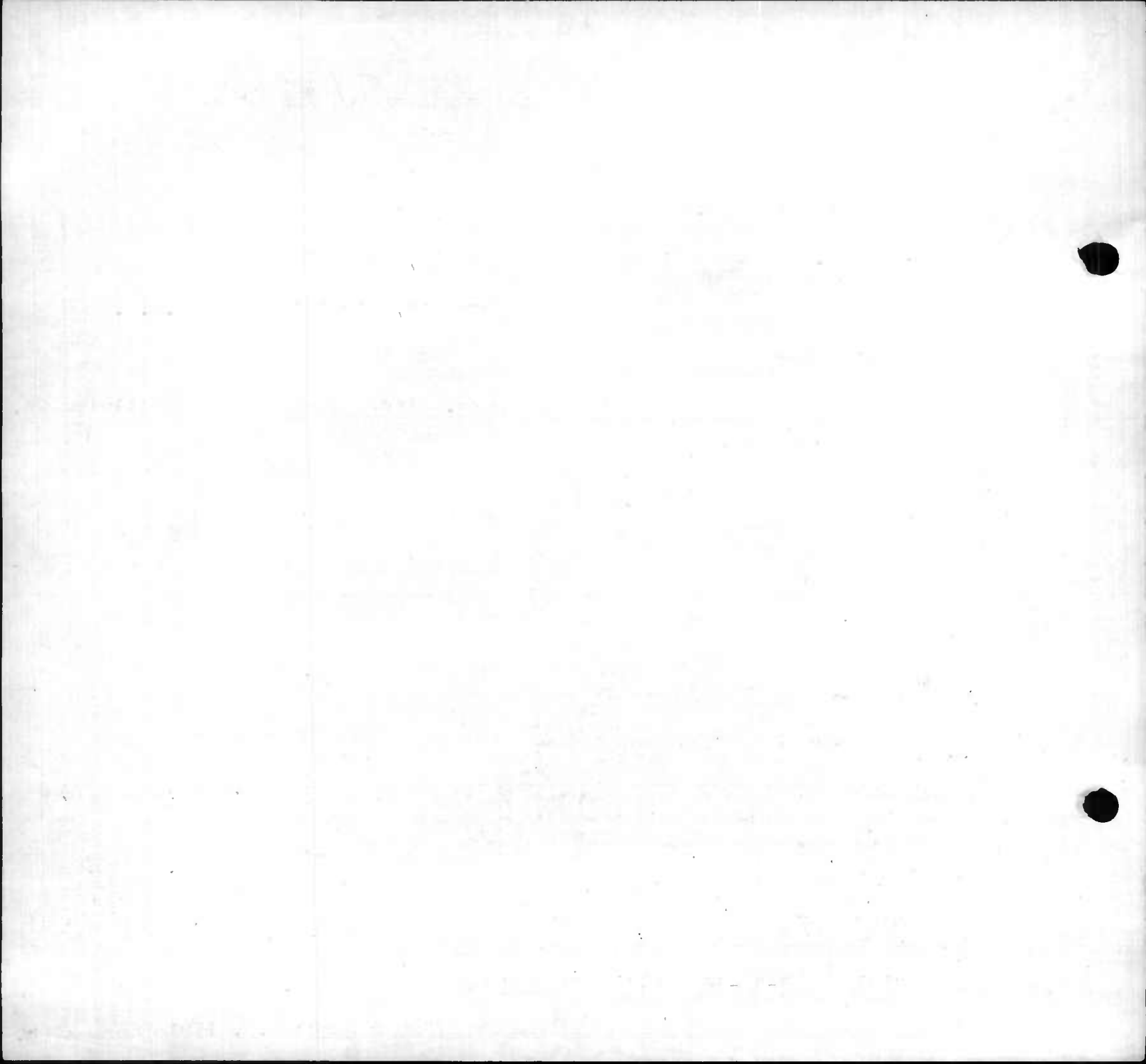
Robert E. Taylor, M.D.

Charles A. Rice 661 W. Barre St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09404</u> | |
|---|----------------------|--|---|---|---|
| BIRTH NO. <u>66 09404</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MILTON LAWS</u> | | 2. DATE AND HOUR OF DEATH <u>9/16/66</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>601 Hillview Road</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>25-32</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>601 Hillview Rd</u> | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>N.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Jan 19, 1896</u> | 9. AGE (in years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Accomac, Virginia</u> | |
| 13. FATHER'S NAME <u>Acustis Laws</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Laws</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Mrs. Gladys Reed 644 Hillview Rd.</u> | |
| 18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>CORONARY HEART DISEASE</u> DUE TO (B) <u>Chr. Arteriosclerotic Heart</u> DUE TO (C) <u>Chr. Nephritis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>8 yrs</u> <u>3 wks</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 1958</u> to <u>9-17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-12</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jerry C. Luck</u> M.D. | | | | 23B. DATE SIGNED <u>Sept. 17, 1966</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jerry C. Luck</u> M.D. | | | | 23D. ADDRESS <u>427 Swale Road, Balto.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-20-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u> | |
| 24D. LOCATION <u>Balto.</u> | | 24E. STATE <u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F.H. 1701 Laurens St.</u> | |



66 09405

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09405

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH

PRICE

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966 9:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Balt

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2722 Lodge Farm Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 5, 1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Littleton North Carolina U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Turner Price

14. MOTHER'S MAIDEN NAME

Margaret Faulcon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. James Price 140 Chestnut Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cardiac Tamponade
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Rupture of Myocardial Infarction
DUE TO

(C) Arteriosclerotic Heart Disease.

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-24-66

23C. NAME of CEMETERY or CREMATORY

Littleton Baptist Cem. Littleton North Carolina

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Morton and Dyett Fun'l H. 1701 Laurenc

ADDRESS

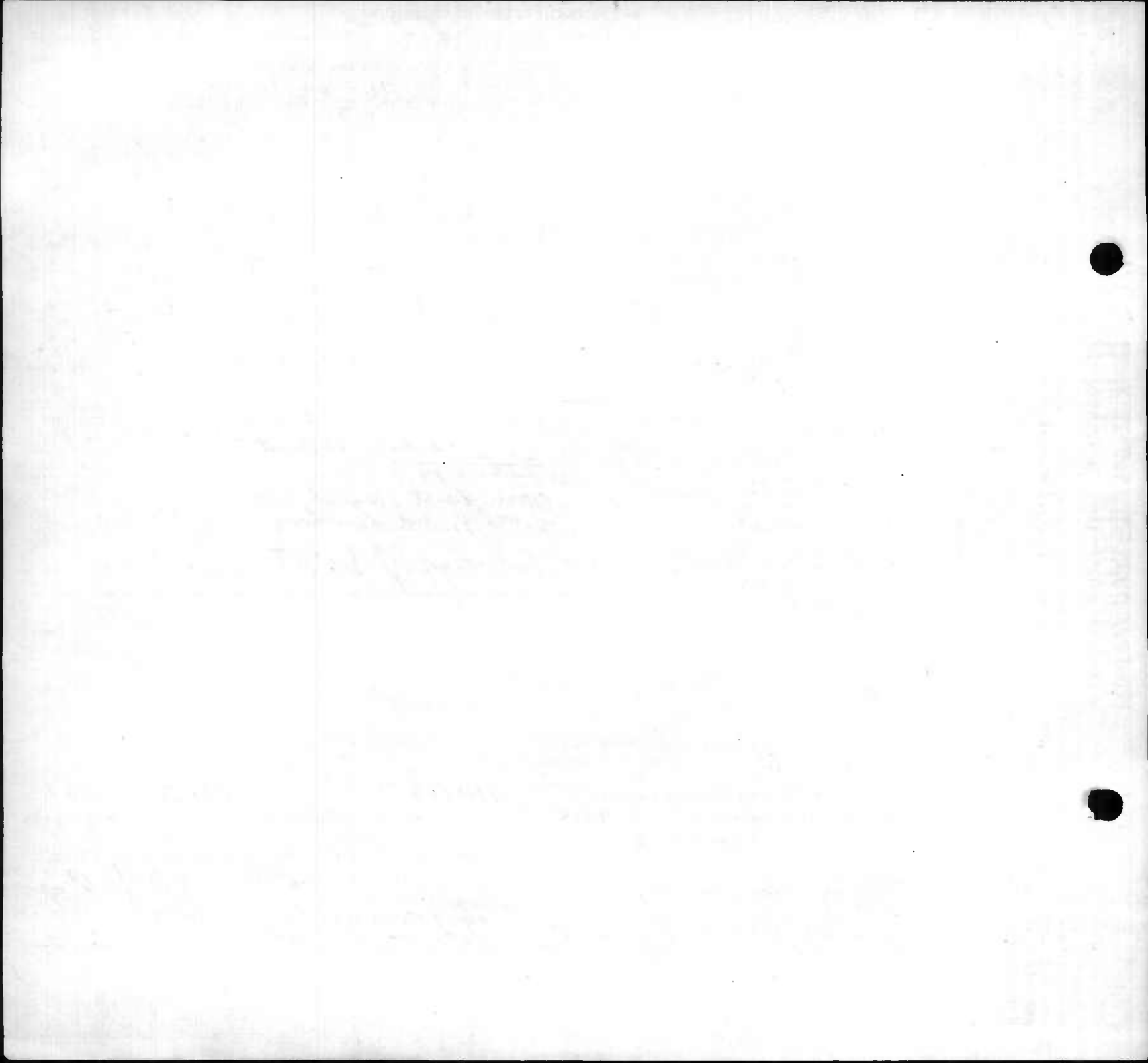
WALLLEY & BRIGHT

1040 CONSTITUTION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09406 | |
| BIRTH NO. 62-11620 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 66 09406 | | 1. NAME OF DECEASED (Type or Print) PURNELL, KEVIN | |
| 2. DATE AND HOUR OF DEATH 9/15/66 0945 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, Md. | | A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-01 D. STREET ADDRESS (If rural, give location) BALTIMORE 423 N. BRICE ST #23 | |
| 5. SEX M | 6. RACE negro | 7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 5-3-62 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) 4 |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIE PURNELL | | 14. MOTHER'S MAIDEN NAME JULIE HERRING | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. --- | 17. INFORMANT Mrs Julie Purnell |
| 18. 754.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac arrest (A) Fetalogy DUE TO Open heart surgical repair (B) yesterday, and hemorrhage DUE TO (C) Tobology / Fallot | | INTERVAL BETWEEN ONSET AND DEATH 17 hrs. 4 yrs. | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 1 9/14/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tobology / Fallot | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12/66 19 to 9/15 19 66 , that (I) (we) lost saw the deceased alive on 9/15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Sidney Wilson Tiesenga | | 23B. DATE SIGNED 9/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY WILSON TIESENGA | | 23D. ADDRESS 7469 FURNACE BRANCH Rd Ant F GLEN BURNIE Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-19-66 | 24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cemetery | 24D. LOCATION (City, town, or county) (State) Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | 25B. NAME OF REGISTRAR Robert E. Farley | 25C. FUNERAL DIRECTOR Mortone Rye H. F.H. | ADDRESS 1701 Laurens St |



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R 200

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 09407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09407

M.E. CASE NO.

| | | | | | | | |
|--|-------------------------|--|---|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) PAUL ROOKS | | | | 2. DATE AND HOUR PRONOUNCED DEAD September 14, 1966 3:20 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-38 C. CITY OR TOWN (If outside corporate limits, write RURAL and give town) Baltimore D. STREET ADDRESS (If rural, give location) 3321 Liberty Heights Avenue | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH April 22, 1943 | | 9. AGE (In years last birthday) 23 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Balto, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Whit Rooks | | | | 14. MOTHER'S MAIDEN NAME Bessie Massenburg | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Lovellen Rooks | | ADDRESS 1120 Wicklow Rd | |
| 18. CAUSE OF DEATH E 816.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries. INTERVAL BETWEEN ONSET AND DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Liberty Hgts., W. of Burleith St. | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9 14 '66 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Driver in auto-bus collision. | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/15/66 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9-19-66 | | 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 23D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 24B. NAME OF REGISTRAR Robert E. Fadden | | 24C. FUNERAL DIRECTOR Morton E. Dyett F.H. | | ADDRESS 1701 Laurens St | |

WALLLEY PROCTOR

PROCTOR

1852

1851

FUNERAL DIRECTOR: IMPORTANT

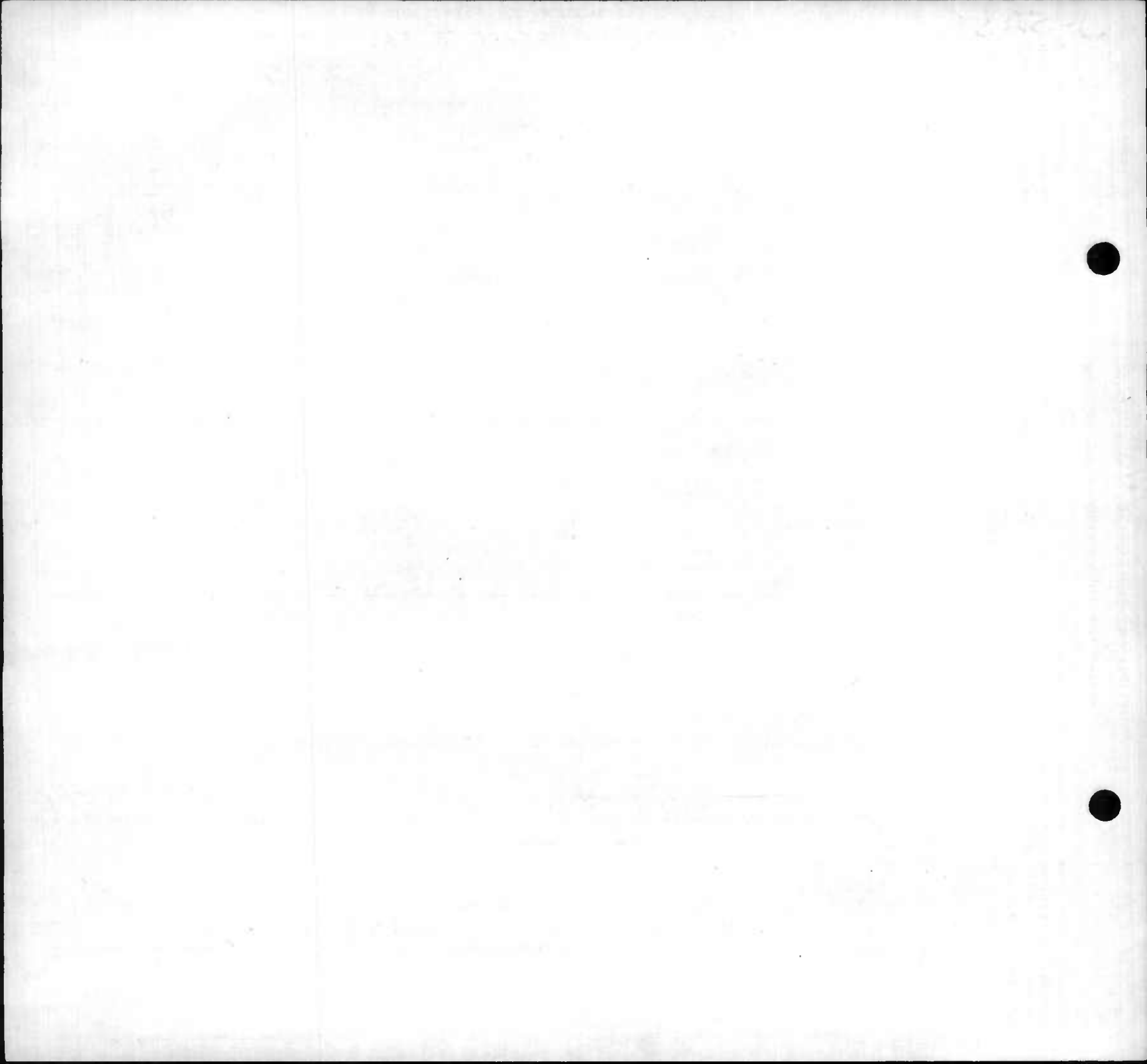
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09408</u> | |
|---|--|--|---|--|---|
| BIRTH NO. <u>66 09408</u> | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM HENRY MATTHEWS</u> | | | 2. DATE AND HOUR OF DEATH <u>7¹⁰ A.M. 9/16/66</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIV. HOSP.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALT.</u> <u>14-03</u> | | |
| 5. SEX <u>M</u> | | | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEP.</u> | 8. DATE OF BIRTH <u>11-4-31</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMP.</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 9. AGE (In years last birthday) <u>35</u> |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>WILLIAM MATTHEWS</u> | | | 14. MOTHER'S MAIDEN NAME <u>EMMA HOPKINS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES ?</u> | | | 16. SOCIAL SECURITY NO. <u>21826 7875</u> | | 17. INFORMANT <u>Mrs. Emma Matthews</u> |
| 18. <u>581.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u> | | | CAUSE OF DEATH (A) <u>PULM. HEMORRHAGE</u> DUE TO <u>THROMBOCYTOPENIA</u> (B) <u>HYPOFIBRINOGENEMIA</u> DUE TO <u>HYPERSPLENISM 2°</u> (C) <u>PORTAL HYPERTENSION 2°</u> <u>ALCOHOLIC CIRRHOSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>SEVERAL MOS (4 YRS)</u> <u>SEVERAL YRS (MANY YRS)</u> |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netely medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(this hospital)</u> attended the deceased from <u>8/7/66</u> 19 to <u>9/16/66</u> 19, that <u>(I)</u> (we) lost saw the deceased alive on <u>9/16/66</u> 19 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>H. Lander Kiraspe</u> | | | | 23B. DATE SIGNED <u>9/16/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>—</u> | | | | 23D. ADDRESS M.D. <u>UNIV. HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-19-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cemetery Balto.</u> | |
| 24D. LOCATION <u>MD.</u> | | 24E. NAME of REGISTRAR <u>Robert E. Farber</u> | | 24F. FUNERAL DIRECTOR <u>Mortane E. Dyett</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR <u>Mortane E. Dyett</u> | |
| 25D. ADDRESS <u>1701 LAWRENCE ST.</u> | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09409 | |
|---|-------------------------|---|---|---|--|
| BIRTH NO. 66 09409 | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ALFRED JENKINS | | | 2. DATE AND HOUR OF DEATH SEPT 15, 1966 12:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTO. MD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 507 ROBERT ST 17 | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 11-28-10 | 9. AGE (In years last birthday) 55 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Issac Jenkins | | |
| 14. MOTHER'S MAIDEN NAME Hessie Bowman | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 215-05-6479 | | | 17. INFORMANT ADDRESS Alfred Jenkins, Jr. 3002 Roseland Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 300X1 | | | CAUSE OF DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO Pneumonia | | |
| | | | (B) DUE TO Aspiration | | |
| | | | (C) Cerebral Anoxia secondary to Seizure | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (the hospital) attended the deceased from 9-2 1966 to 9-15 1966 , that (I) (we) last saw the deceased alive on 9-15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William R. Law | | | | 23B. DATE SIGNED 9-15-66 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM R. LAW | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-19-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) A.A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | |
| 25B. NAME OF REGISTRAR R. E. E. E. | | 25C. FUNERAL DIRECTOR ADDRESS Mortene Dyett F.H. 1701 Laurens St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09410 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09410 | |
|---|---------------------|--|------------------------------------|--|----------------------------|---|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type and print) JAMES F. SARNECKI | | | | 2. DATE AND HOUR OF DEATH SEPT. 16, 1966 7:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 1-03 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2414 FLEET ST. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/21/10 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIE OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY WESTERN ELECTRIC | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME LOUIS SARNECKI | | | | 14. MOTHER'S MAIDEN NAME PAULINE DRANKA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213036309 | | 17. INFORMANT ADDRESS MRS. MARIE SARNECKI-2414 FLEET ST. | |
| 18. 420.11-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 7 1/2 HRS | | | | CAUSE OF DEATH (A) DUE TO ASCVD | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS | | | | (B) DUE TO (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/16/65 to 9/16/66 and that (I) (we) last saw the deceased alive on 9/16/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald Weber | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 16, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) MD General Hospital | | | | 23D. ADDRESS MD General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS | | 24D. LOCATION (City, town, or county) (State) BALTIMORE - MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Sawyer, M.D. | | 25C. FUNERAL DIRECTOR GEORGE A. WEBER-705 S. ANN ST. | | ADDRESS | |

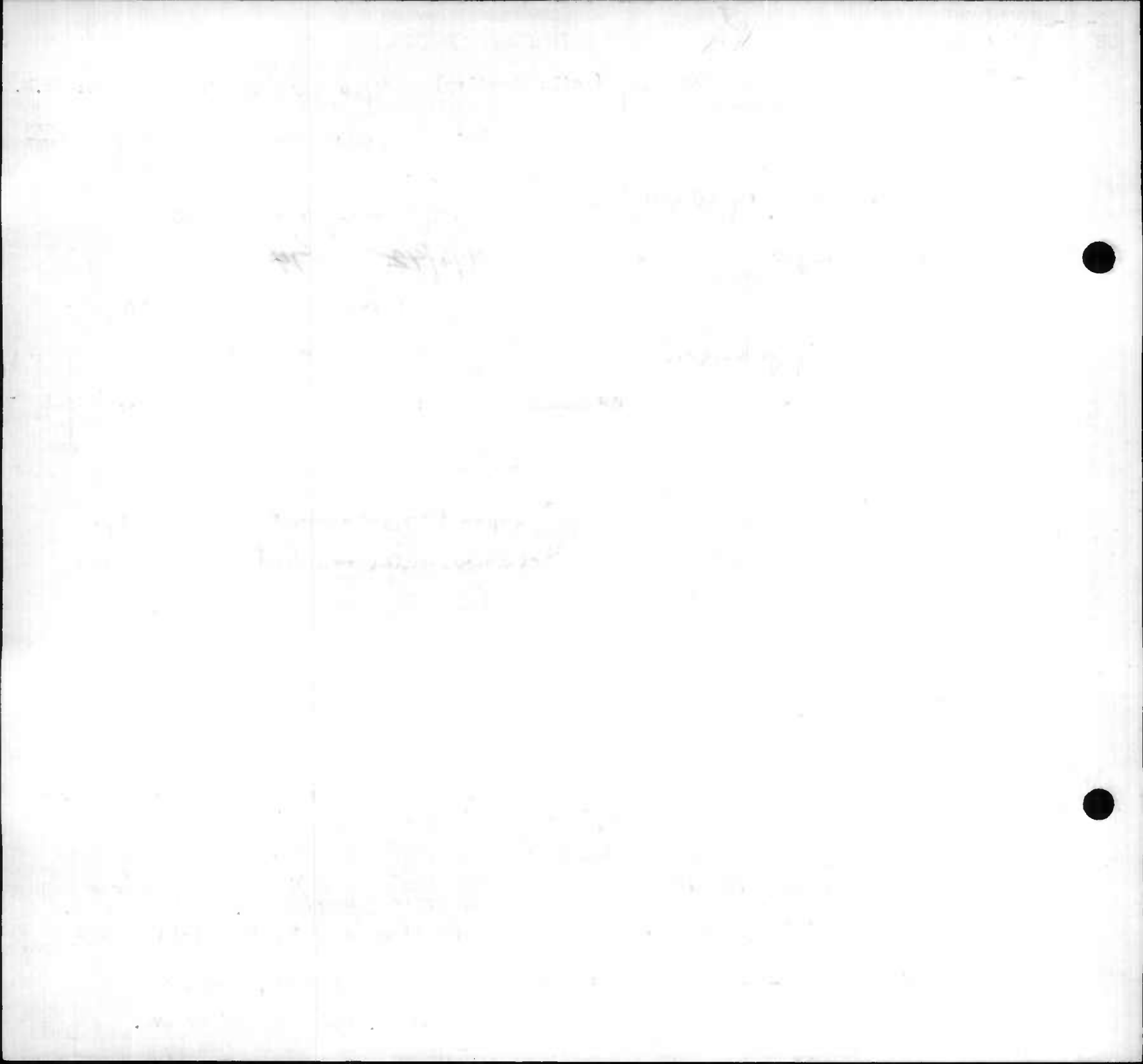
[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

42-49-26
DH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

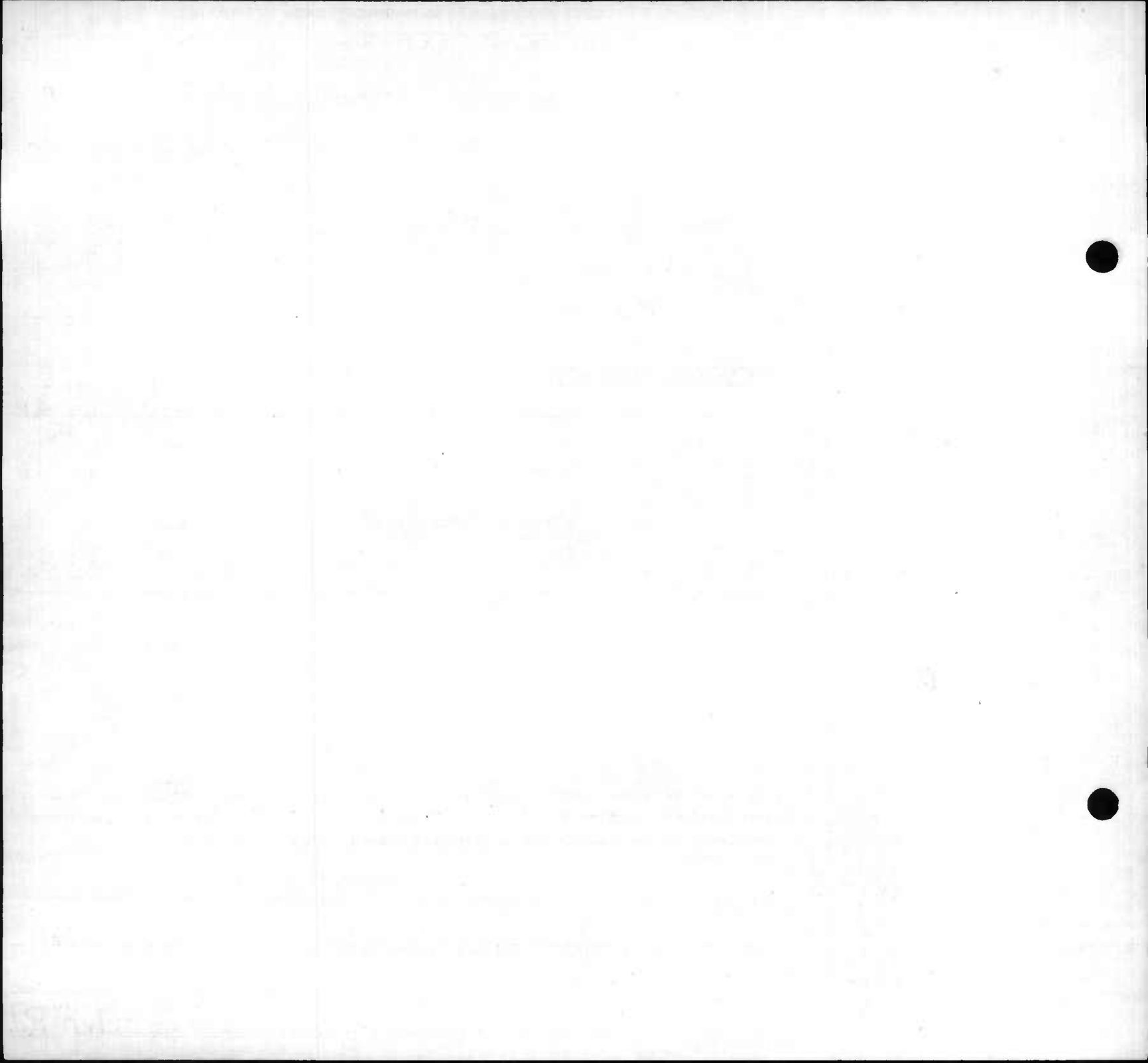
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09411 | |
|--|-------------------------|---|--|---|--|
| BIRTH NO. 340 66 09411 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Leila Wheatley (Leila Wheatley)</i> | | | | 9/16/66 6 PM 6:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Baltimore City Hospitals #21224</i> <i>4940 EASTERN AVE. BALTIMORE, MARYLAND</i> | | | | A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2417 Shirley Ave. #21215</i> | |
| 5. SEX <i>female</i> | 6. RACE <i>negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i> | 8. DATE OF BIRTH <i>4/6/92</i> | 9. AGE (In years lost birthday) <i>74</i> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none (NONE)</i> | | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND (not known)</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Wesley Johnson</i> | | | 14. MOTHER'S MAIDEN NAME <i>Sara Gatewood</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. <i>not known</i> | | |
| 17. INFORMANT <i>BALTIMORE CITY HOSPITAL RECORDS: 4940 EASTERN AVE. BALTO., MD. #24</i> | | | 18. CAUSE OF DEATH | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>aspiration pneumonia</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>cardiovascular accident</i> | | | <i>2 years</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2 none</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1</i> 19 <i>66</i> to <i>Sept 16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept 16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Bruce M. Dow</i> | | | | 23B. DATE SIGNED <i>9/16/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>BRUCE M. DOW</i> | | | | 23D. ADDRESS <i>4940 EASTERN AVE. BALTIMORE, MD. Baltimore City Hospitals #21224</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-20-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Falcione</i> | | 25C. FUNERAL DIRECTOR <i>Charles R. Law</i> | | | |
| 25D. ADDRESS <i>802 Madison Ave.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>66 09412</u> | |
|---|----------|--|--|--|------------------------------------|--|--|
| BIRTH NO. <u>66 09412</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Florence Virginia Dennis</u> | | | | 2. DATE AND HOUR OF DEATH <u>Sept 17, 1966 1:35 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| | | <u>2850 Clifton Ave.</u> | | <u>2850 Clifton Ave.</u> | | <u>15-47</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | <u>Baltimore Md. 21216</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | <u>2850 Clifton Ave</u> | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days Hours Min. | |
| <u>F</u> | <u>C</u> | <u>Widow</u> | | <u>9/23/04</u> | <u>61</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Domestic</u> | | <u>none</u> | | <u>Blackstone, Va.</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Ned Coleman</u> | | | | <u>Lucy Johnson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| <u>no</u> | | <u>215-32-2527</u> | | <u>Florence D. Bailey</u> | | <u>3707 Edge-wood Rd.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| <u>443 X 1 + 260 X</u> | | | | <u>Cerebral accident</u> | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <u>Hypertensive C.V.D.</u> | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>Diabetes mellitus</u> | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22A. AUTOPSY? (Yes or No) | | 22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| <u>0</u> | | | | <u>No</u> | | | |
| 23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 24D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 24E. INJURY OCCURRED | | 24F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> <u>1960</u> to <u>9-17-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>8-8-</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| <u>C.R. Campbell</u> | | | | | | <u>9-19-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| <u>C.R. Campbell</u> | | | | <u>1618 W. North Ave. Baltimore Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>9/20/66</u> | | <u>Arbutus Cemetery</u> | | <u>Sulphur Spring Rd. Balto Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| <u>SEP 19 1966</u> | | <u>Robert E. Taylor</u> | | <u>Wilton R. Webb</u> | | <u>3613 Dennlyn Rd. 15</u> | |



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66 09413

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09413

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) EVERETT SHIVELY | | 2. DATE AND HOUR PRONOUNCED DEAD September 17, 1966 5:15 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lord Baltimore Hotel Baltimore & Hanover Streets | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Ohio B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Columbus D. STREET ADDRESS (If rural, give location) Plains City | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 5, 1887 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 79 |
| 13. FATHER'S NAME Unknown | | 11. BIRTHPLACE (State or foreign country) Loganport, Ind. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME Hofford | |
| 17. INFORMANT Weir-Arend Funeral Home, Columbus, Ohio | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Removal - BURIAL | | 23B. DATE 9/17/66 | |
| 23C. NAME OF CEMETERY or CREMATORY Glenn Rest Cem. | | 23D. LOCATION (City, town, or county) (State) Columbus, Ohio | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 24C. FUNERAL DIRECTOR James M. Fields, M.D. | | ADDRESS | |

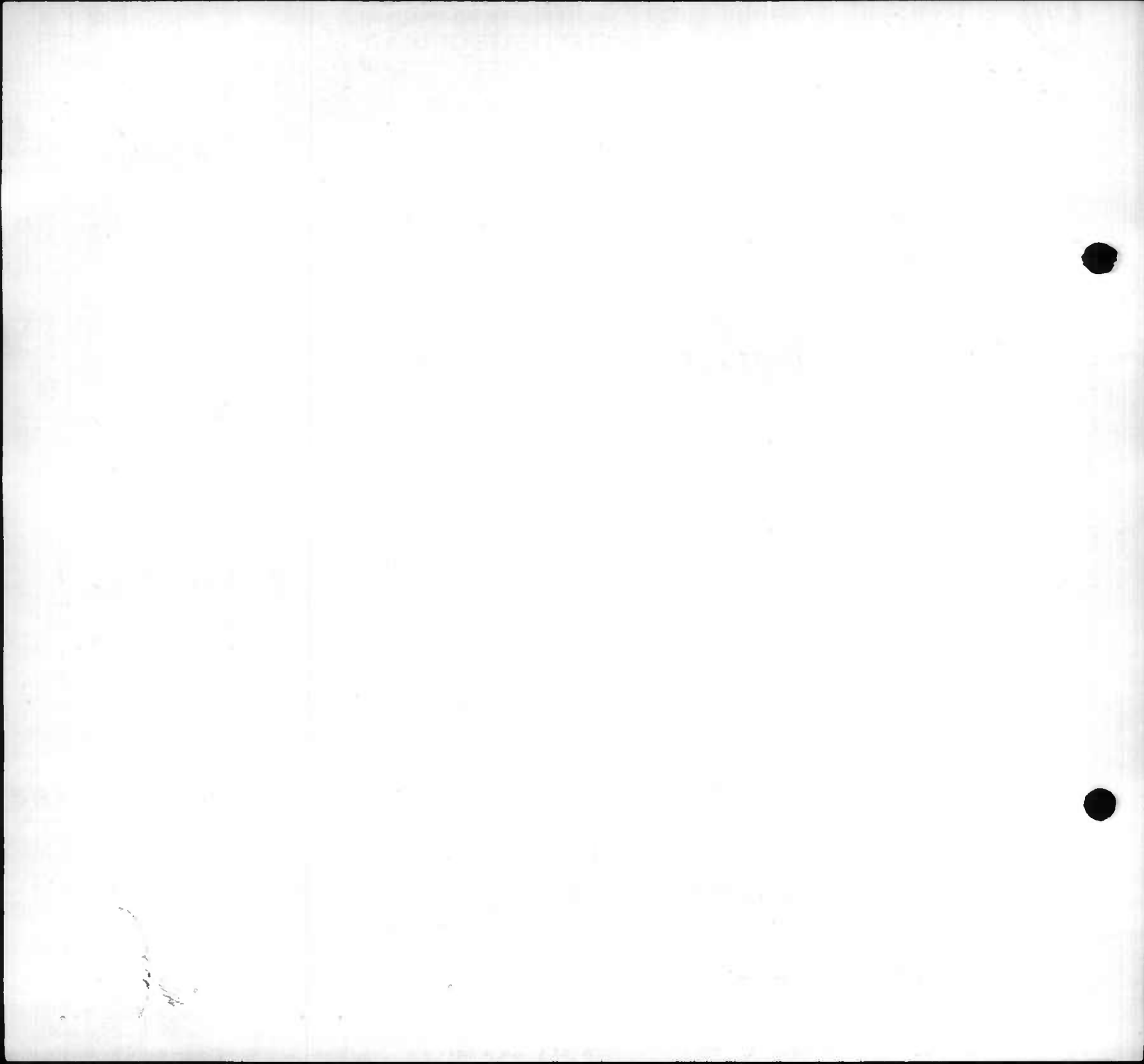
WATKINS FORD

12/10/1910
J. K. [unclear]
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---------------------|--|-------------------------------------|--|--|
| B-324 66 09414 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09414 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Battaglia, Joseph</u> | |
| 2. DATE AND HOUR OF DEATH <u>9-18-66</u> <u>7:05 a.m.</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | D. STREET ADDRESS (If rural, give location) <u>807 COOKS Lane</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>11/21/92</u> | 9. AGE (In years last birthday) <u>73</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Phillip Battaglia</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Maria</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Admission Sheet.</u> | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Esophagus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| 19. DATE OF OPERATION <u>0</u> | | 20. AUTOPSY? (Yes or No) | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 12, 1966</u> to <u>Sept. 18, 1966</u> . that (I) (we) last saw the deceased alive on <u>Sept. 18, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23. SIGNATURE <u>Nam Dooh Yang</u> | | 23B. DATE SIGNED <u>Sept. 18, '66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NAM DOH YANG</u> | | 23D. ADDRESS <u>Bon Secours Hospital</u> | | 24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 24B. DATE <u>9-21-66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert S. Feltner</u> | | 25C. FUNERAL DIRECTOR <u>Witzke F. D.-4101 Edmondson Av.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|---|---------------------------------|--|--|
| BIRTH NO. 1H 400 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09415 | |
| M.E. CASE NO. 66 09415 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Holbury, Orlie</i> | | 2. DATE AND HOUR OF DEATH <i>9-17-66</i> <i>8:45</i> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i> | | A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>20-07</i> D. STREET ADDRESS (If rural, give location) <i>522 Mt. Holly Street</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>7-27-91</i> | 9. AGE (In years last birthday) <i>75</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>C & P Telephone Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Harry</i> | | 14. MOTHER'S MAIDEN NAME <i>Isabelle</i> | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>212-03-6921</i> | | 17. INFORMANT <i>Patience's Chart</i> ADDRESS | |
| 18. <i>331 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) <i>AS subdural hematoma</i> DUE TO <i>massive</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (the) (this hospital) attended the deceased from <i>2:45 pm 9-17</i> 19 <i>66</i> to <i>8:50 pm 9-17</i> 19 <i>66</i> . that (I) (we) last saw the deceased alive on <i>9-17 8:45 pm</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Y. Chung</i> | | M.D. <i>Y. CHUNG</i> | | 23B. DATE SIGNED <i>9-17-66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <i>Bon Secours Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-20-66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Louder Park Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) | | <i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 19 1966</i> | | 25B. NAME OF REGISTRAR <i>R. E. Fajana</i> | | 25C. FUNERAL DIRECTOR <i>Witzke F. D.</i> ADDRESS <i>-4101 Edmondson Av.</i> | |

[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page. The text is mostly centered and spans several lines.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------|--|--|--|---|--|--|---------------------------------|----------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 66 09416 | | | | |
| BIRTH NO. 66 09416 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) SAMUEL J. SHAPOS | | | | | 2. DATE AND HOUR OF DEATH SEPT 17 1966 6:00 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL | | | | | A. STATE MARYLAND | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15 27-19 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 5718 NARCISSUS AVE | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9-13-10 | 9. AGE (In years last birthday) 56 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXXXXXXXXXX | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JEWELRY JACOB SHAPOS | | | 14. MOTHER'S MAIDEN NAME ROSE - - - - ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | |
| 16. SOCIAL SECURITY NO. 219-32-0484 | | | 17. INFORMANT ADDRESS MRS. PEGGY SHAPOS, 5718 NARCISSUS AVENUE | | | | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) ACUTE PULMONARY EDEMA 2 HOURS (B) ACUTE MYOCARDIAL INFARCTION 2 HOURS (C) ARTERIOSCLEROTIC HEART DISEASE 4 YEARS | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT. 17, 1966 to SEPT 17 1966, that (I) (we) last saw the deceased alive on SEPT 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Honorio R. Ylizarde Jr. M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED sept. 17, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) HONORIO R. YLIZARDE JR. M.D. | | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/19 66 | | 24C. NAME OF CEMETERY or CREMATORY BETH JACOB | | 24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | 25B. NAME OF REGISTRAR Robert E. Farber | | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09417 |
|---|-----------------------------|--|---|--|
| BIRTH NO. 66 09417 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Schwartz William BARNEY</i> | | 2. DATE AND HOUR OF DEATH <i>9/16/66 5:19 P.M.</i> |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, with RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>5622 GREENSPRING AVENUE</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i> | | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>DEC. 25, 1894</i> | 9. AGE (In years last birthday) <i>71</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>SHOE</i> | 11. BIRTHPLACE (State or foreign country) <i>LAURENCEVILLE, VIRGINIA</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>JACOB ISAAC SCHWARTZ</i> | | 14. MOTHER'S MAIDEN NAME <i>MENNIE KLEIN</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>W.W. 1 YES</i> | | 16. SOCIAL SECURITY NO. <i>UNKNOWN</i> | 17. INFORMANT <i>MRS. SYBIL SCHWARTZ, 5622 GREENSPRING AVENUE</i> | |
| 18. <i>73411</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary Edema</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> | | (A) DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <i>Chronic Cong. Heart Failure 3 mos.</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> 19 <i>66</i> to <i>9/16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE <i>R. L. Young, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED <i>9/16/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>R. L. YOUNG, JR.</i> | | 23D. ADDRESS <i>SINAI HOSPITAL</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>9/18/66</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>HEBREW FRIENDSHIP</i> | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN</i> | | |

52 011

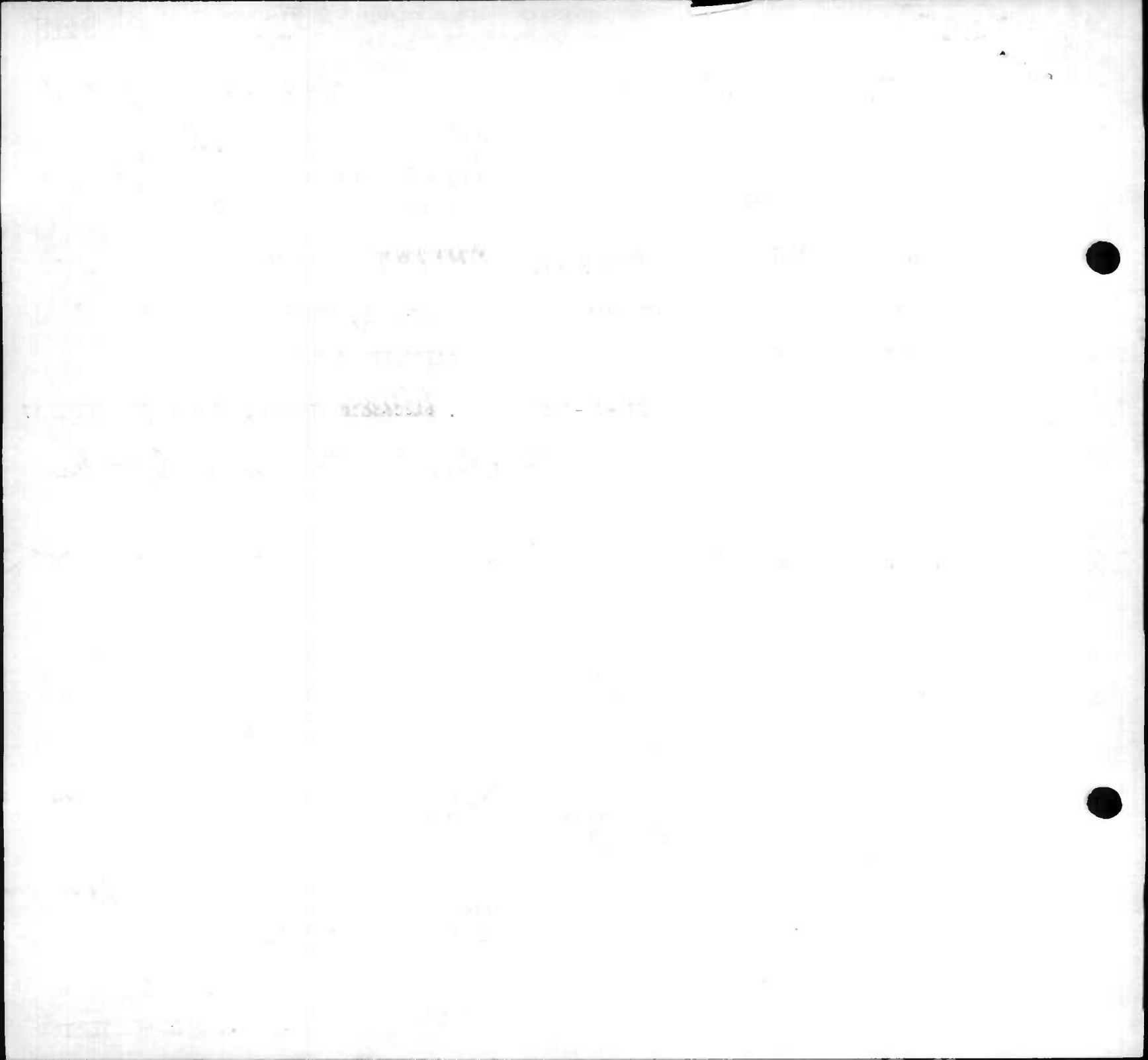
1



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

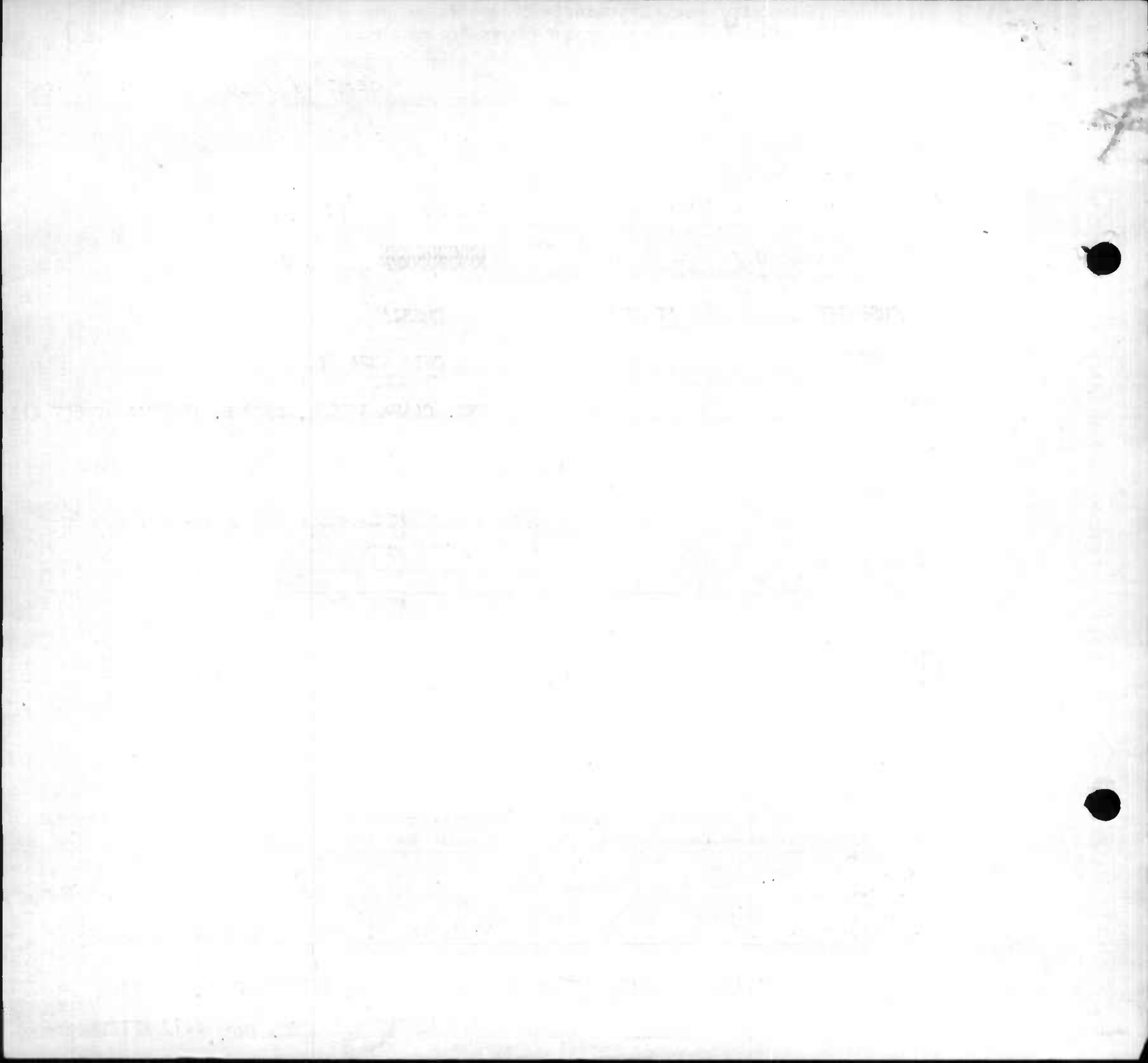
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | |
|---|---------|--|------------------|--|--|--|------------------------------|
| BIRTH NO. | | 66 09418 | | CERTIFICATE OF DEATH | | 66 09418 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | FRANK WINAKUR | | 9/14/66 7:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 42 SINAI HOSPITAL | | | | MD. Balto | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALT. MORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 6700 - LAUREL DR | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| MALE | W | MARRIED | 9/14/66 | 57 | | BALTIMORE, MARYLAND | USA |
| 13. FATHER'S NAME | | 108. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| JACOB WINAKUR | | JEWELRY | | BALTIMORE, MARYLAND | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 215-12-1036 | | MRS. Edith WINAKUR | | 6700 LAUREL DRIVE #7 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 390 X I | | | | CEREBRAL THROMBOSIS 5 weeks | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/26 1966 to 9/14 1966, that (I) (we) last saw the deceased alive on 9/14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| S. Gordon | | | | | | 9/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| S. GORDON | | | | M.D. SINAI HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 9/18/66 | | BETH TELLER | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 19 1966 | | Robert E. Taylor, M.D. | | SOL LEVINSON & BROS. INC. | | 6010 REISTERSTOWN | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|--|---|---|---|
| BIRTH NO. 66 09419 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09419 | |
| 1. NAME OF DECEASED (Type or Print) GLAZER, SOPHIE | | | 2. DATE AND HOUR OF DEATH SEPT. 14, 1966 11 30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, MD. | | | A. STATE MD. B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 2309 E. FEDERAL ST. | | |
| 5. SEX F | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH XXXXXXXXXX | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME CHIA SURA ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | 17. INFORMANT MRS. CLARA JOSEPH, 2309 E. FEDERAL STREET #13 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) APASTIC ANEMIA INTERVAL BETWEEN ONSET AND DEATH 2 wks | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CYSTADENOCARCINOMA OF OVARY 15 yrs E PULMONARY MPT | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/8/66 to 9/14/66 , that (1) (we) last saw the deceased alive on 9/14/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kurt P. Sligar | | | | 23B. DATE SIGNED 9/14/66 | |
| 23C. PHYSICIAN'S NAME (Type) KURT P. SLIGAR | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/18/66 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW | |
| | | | | 24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN | |



R-150

66 09420

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09420

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACK RUBIN

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1966 5:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3600 Block Parkview Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6800 Liberty Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 17, 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Proprietor

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Rubin

14. MOTHER'S MAIDEN NAME

Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sadie Rubin 6800 Liberty Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street (auto)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3600 Block Parkview Drive

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 16 '66

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head (Found in parked auto)

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
9/17/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/1966

23C. NAME of CEMETERY or CREMATORY

Shaarei Zion

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 19 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

Sol Levinson & Bros. 6010 Reisterstown Rd.

WALTER E. FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|---|--|--|
| BIRTH NO. 66 09421 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09421 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BESSIE MUSNICK | | 2. DATE AND HOUR OF DEATH 9/15/66 7:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-12 | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 2445 SHIRLEY AVE #15 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH APRIL 1 1888 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 218-52-4805 | | 17. INFORMANT ADDRESS SON - MEYER MUSNICK 8148 Scotts Level | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA | | CAUSE OF DEATH (A) DUE TO MYOCARDIAL infarction | | INTERVAL BETWEEN ONSET AND DEATH 5 HOURS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (B) DUE TO | | (C) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIO SCLEROSIS | | YEARS | | | |
| 19A. DATE OF OPERATION 0 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30/66 to 9/15/66 , that (I) (we) last saw the deceased alive on 9/15/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Eduardo Hidalgo M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.D. | | | | 23D. ADDRESS SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/18/66 | | 24C. NAME of CEMETERY or CREMATORY WORKMEN CIRCLE | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D. BY HEALTH DEPT. SEP 19 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN | | | |

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9/12/50

9/12/50

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EDUARDO MICALDO

FOR APPROVAL OF MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09422 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09422 | |
|---|---------------------|--|---|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>RITA L. LANDINO</u> | | | | 2. DATE AND HOUR OF DEATH <u>9-18-66</u> <u>7:25 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MERCY HOSPITAL.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3911 EIERMAN Ave.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>1-9-15</u> | 9. AGE (In years last birthday) <u>51</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | | 13. FATHER'S NAME <u>Louis MAIVELLE Maivelle</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>ANTOINETTE IZZO.</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>Frank J Landino</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>POST-OP BLOOD LOSS DUE TO UNCONTROLLABLE Oozing OF BLOOD</u> <u>Following Cholecystectomy</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hr.</u> | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>HYPERTENSIVE ASCUD</u> <u>DIABETES MELLITUS.</u> | | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION <u>9-17-66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CHOLELITHIASIS.</u> | | 20A. AUTOPSY? (Yes or No) <u>No.</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> 19 <u>66</u> to <u>9-18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <u>Leonard J. Sawbaker</u> M.D. | |
| 23B. DATE SIGNED <u>9-18-66</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Leonard J. Sawbaker</u> | | 23D. ADDRESS <u>Baltimore Maryland</u> | | 23E. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/22/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Garden Of Faith</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc 5305 Harford Rd</u> | | 25D. ADDRESS | |

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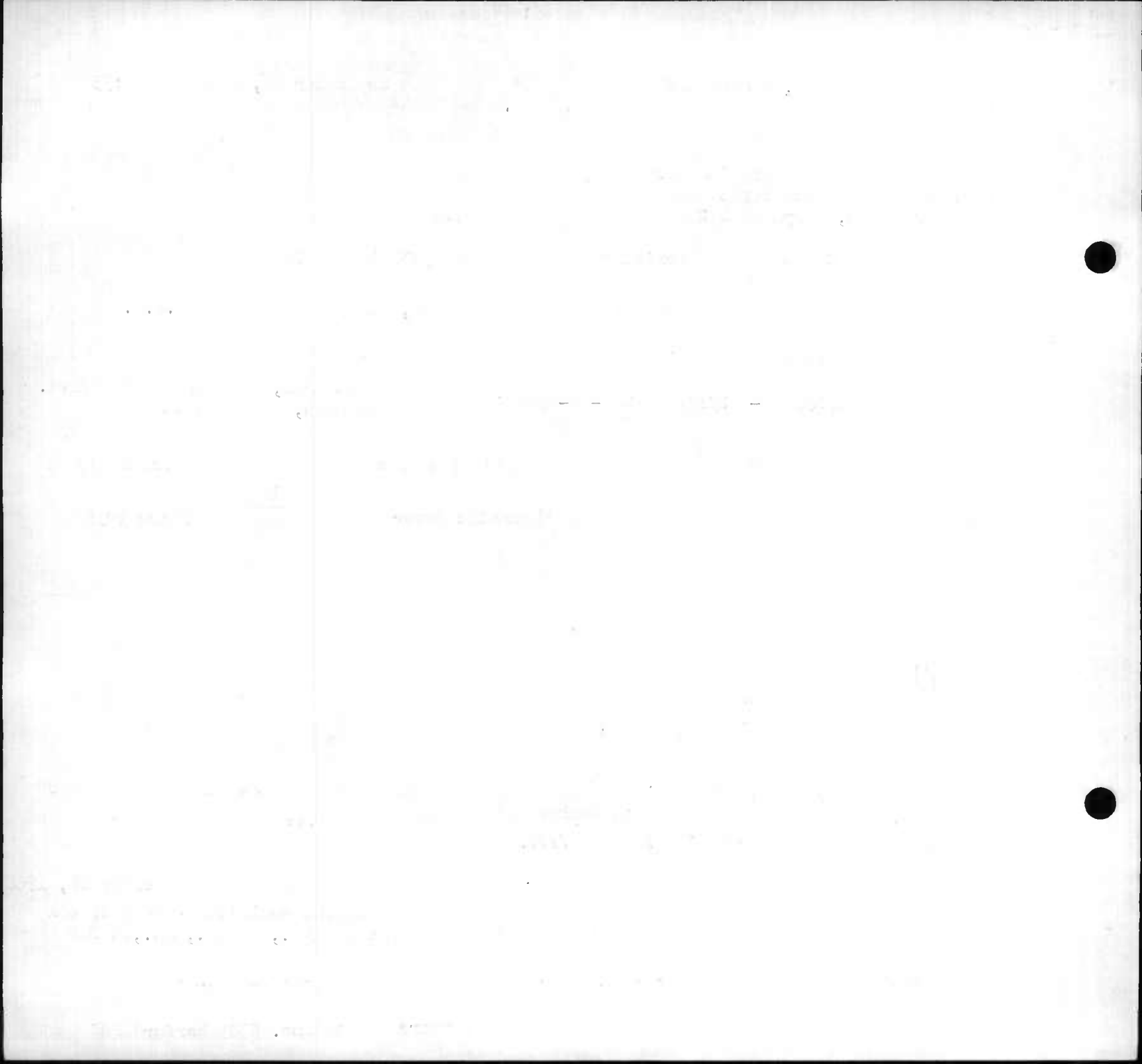
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

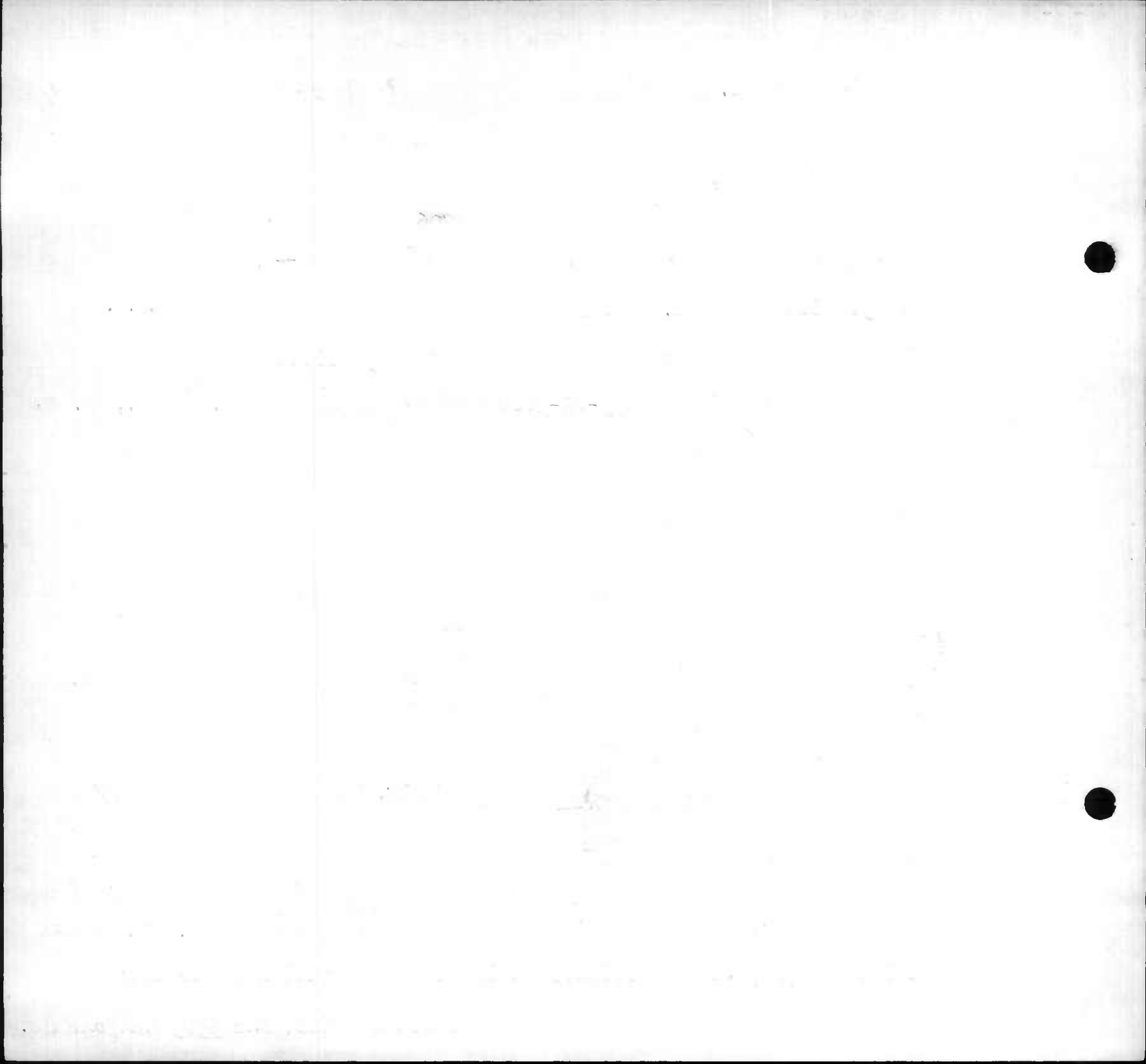
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|--|-------------------------|---|---|--|---|
| 66 09423 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09423 | |
| BIRTH NO. | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LAMARTINA, Samuel NMI | | | 2. DATE AND HOUR OF DEATH September 16, 1966 6:35 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4915 Catalpha Road | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/14/93 94 | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Produce | | 11. BIRTHPLACE (State or foreign country) Sicily, Italy | |
| 13. FATHER'S NAME Joseph Lamartina | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/23/18 - 12/16/18 | | | 14. MOTHER'S MAIDEN NAME Mary Dinkaspino | | 16. SOCIAL SECURITY NO. 217-07-1794 |
| 17. INFORMANT ADDRESS VA Hospital Records, 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I Aortic Stenosis INTERVAL BETWEEN ONSET AND DEATH over 20 years | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Rheumatic Fever since 1918 | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 14th 1966 to September 16th 1966 , that (I) (we) last saw the deceased alive on September 16th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young E. Chun M.D. | | | | 23B. DATE SIGNED September 16, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG CHUN | | 23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md., 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/66 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | |
| 25B. NAME OF REGISTRAR Leonard J Ruck Inc. | | 25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|---|--|
| 42-82-98 DH | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09424 | |
| BIRTH NO. 32 66 09424 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES L. SNODGRASS | | | 2. DATE AND HOUR OF DEATH 9-17-66 - 9 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224 BALTIMORE CITY HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-03 D. STREET ADDRESS (If rural, give location) 2706 GOODWOOD RD. #21214 | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-8-13 | 9. AGE (In years last birthday) 52 53 yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Examiner |
| 10B. KIND OF BUSINESS OR INDUSTRY Md. State | | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Charles Snodgrass | | | 14. MOTHER'S MAIDEN NAME DORA E Shields | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES UNKNOWN | | 16. SOCIAL SECURITY NO. 235-12-3860 | 17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVE. BALTO., MD. #24 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 13414201X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hodgkins Disease 2 yrs. | | | CAUSE OF DEATH (A) DUE TO Cryptococcal Meningitis 2 mon (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 mon |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 22. I certify that (I) (this hospital) attended the deceased from July 21, 1966 to Sept. 17, 1966 and that (I) (we) lost saw the deceased alive on Sept. 17, 1966 and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE Joe Richmon M.D. | | | 23B. DATE SIGNED 9-17-66 | | 23C. PHYSICIAN'S NAME (Type) JOE RICHMON |
| 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MD. #21224 | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 9/17/66 | | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1966 | | | 25B. NAME OF REGISTRAR Leonard J. Ruck Inc | | 25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. |



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C-462

66 09425

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09425

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

M

Alexander Clark

2. DATE AND HOUR PRONOUNCED DEAD

9/16/66 11:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3604 Delverne Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 5, 1883

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Ship Building

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Clark

14. MOTHER'S MAIDEN NAME

Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-01-3075

17. INFORMANT

ADDRESS

Mrs Mary B Clark 3604 Delverne Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

Sept. 20, 1966

Dulaney Valley

Baltimore

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1966

R. E. E. Taylor, M.D.

Leonard J Rueck Inc. 5305 Harford Rd.

April 2, 1982

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

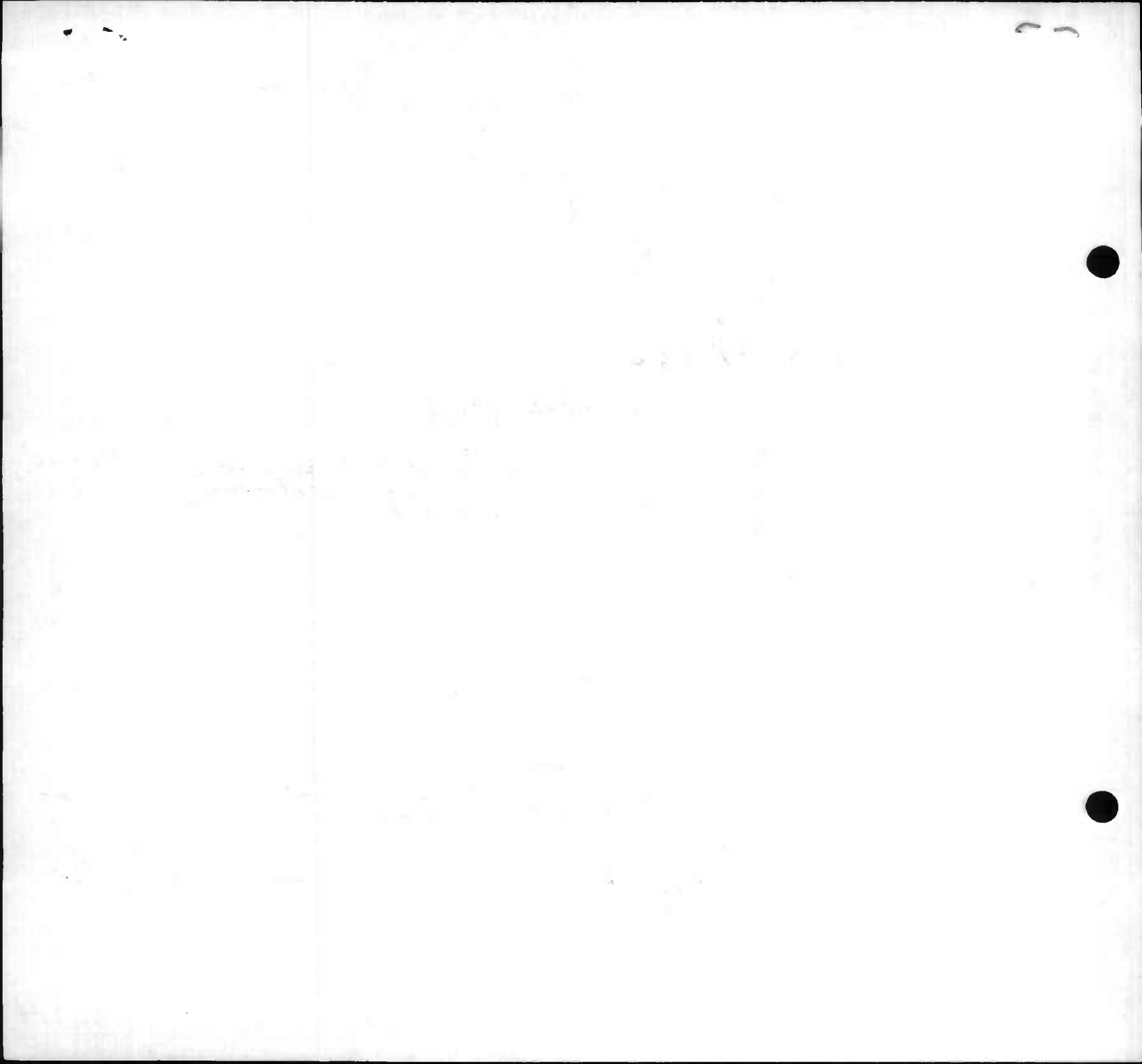
| | | | | | |
|--|------------------|---|---------------------------------|--|---|
| BIRTH NO. 66 09426 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09426 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Oliver Parsons</u> | | 2. DATE AND HOUR OF DEATH <u>9-17-66</u> <u>7:50 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore, Inc.</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2344 Lauretta Ave.</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>9/23/91</u> | 9. AGE (In years lost birthday) <u>74</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Parsons</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Parsons</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>231-10-3427</u> | | 17. INFORMANT <u>Benjamin Parsons</u> ADDRESS <u>2344 Lauretta Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> | | CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u> | | (B) <u>Arteriosclerotic Heart Disease</u> DUE TO | | <u>unknown</u> | |
| (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>MULTIPLE MYELOMA</u> | | <u>?</u> | |
| 19A. DATE OF OPERATION <u>9/20/66</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20A. AUTOPSY? (Yes or No) _____ | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9 September 1966</u> to <u>17 September 1966</u> , that (I) (we) lost saw the deceased alive on <u>17 September 1966</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Michael Levin</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>17 Sep 66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Michael Levin</u> | | 23D. ADDRESS <u>Sinai Hospital of Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/22/66</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u> | |
| 24D. LOCATION (City, town, or county) <u>Arbutus</u> | | (State) <u>MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. _____ | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR <u>Thurmond S. Oden - Balto Md</u> | |
| 25D. ADDRESS _____ | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09427 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09427 | |
|---|---------------------|---|---|--|---|
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Mercurio Dorothy</i> | | 2. DATE AND HOUR OF DEATH <i>9/15/66</i> | | 19 <i>66</i> P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore, Inc.</i> | | A. STATE <i>MD</i> B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>212 N. Clover St.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>MAY 20, 1928</i> | 9. AGE (In years last birthday) <i>38</i> | 10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 13. FATHER'S NAME <i>Andrew Moran</i> | | 14. MOTHER'S MAIDEN NAME <i>Josephine Albers</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i> | | 16. SOCIAL SECURITY NO. <i>219-22-5375</i> | | 17. INFORMANT ADDRESS <i>MR. ULRIC MERCURIO 212 N. CLOVER ST</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>200.01</i> | | CAUSE OF DEATH (A) DUE TO <i>Rectal Cell Sarcoma Pulmonary + Vertebral metastases</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs.</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> 19 <i>66</i> to <i>9/15</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/15</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert L. Young, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/15/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/19/66</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEM.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>B. Dabrowski 2818 E. Baltimore St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09428 | |
|---|---------------------------|--|--|--|--|
| BIRTH NO. 66 09428 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Boozey Theima</i> | | | 2. DATE AND HOUR OF DEATH <i>9/17/66 2:05 P.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>1810 N. MONTEORD AVENUE</i> | | |
| 5. SEX FEMALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH <i>6-2-18</i> | 9. AGE (In years last birthday) <i>48</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i> | |
| 13. FATHER'S NAME HAYWARD BATTS | | | 14. MOTHER'S MAIDEN NAME FANNIE ROUNDTREE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Fannie Oakley</i> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral hemorrhage hypertension | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>9/17/1966</i> to <i>9/17/1966</i> that (I) <i>do</i> last saw the deceased alive on <i>9/17/1966</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>was</i> (did) <i>not</i> view the body after death. | | | | | |
| 23A. SIGNATURE <i>David S. Fedson</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/17/66</i> |
| 23C. PHYSICIAN'S NAME (Type) DAVID S. FEDSON. | | | 23D. ADDRESS JHH | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Sept 21/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>D. C. County Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fedson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>3040 St. Eliection 16297, Columbia St.</i> | | | |



1
B-260

66 09429

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 09429

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

BAKER

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1966

5:45 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1412 E. Madison Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1412 E. Madison Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

April 7, 1920

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer Unemp

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Baker

14. MOTHER'S MAIDEN NAME

Elsie Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elsie Moore 1412 E. Madison St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Asphyxia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

impaction of frankfurter on epiglottis

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1412 E. Madison St.

21D. TIME OF INJURY
(APPROX.)

Sept. 16, 1966

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

choked on food while eating

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 20/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem

23D. LOCATION

(City, town, or county)

(State)

A. D. County Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

J. P. E. Peterson 11297. Carlisle

WALLLEY BOUGE

FUNERAL DIRECTOR: IMPORTANT

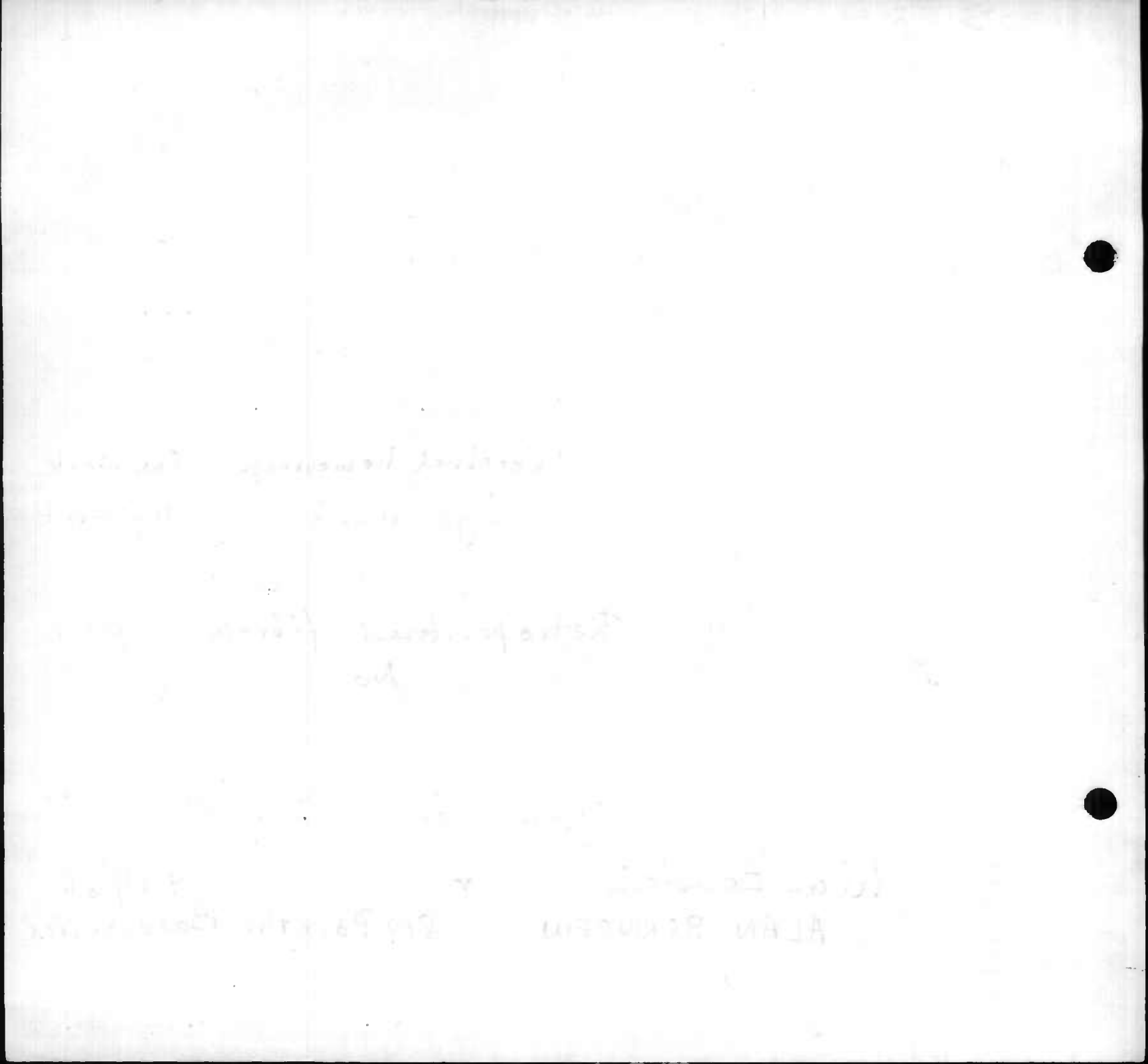
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|--|---|---|---|---|--|
| 66 09430 | | | | | Registered No. 66 09430 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>EDITH THOMAS</u> | | | | | 2. DATE AND HOUR OF DEATH <u>September 13, 1966</u> <u>4</u> <u>30</u> <u>A.</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial L. Hospital</u> | | | | | A. STATE <u>MARYLAND</u> | | | | |
| | | | | | B. COUNTY <u>BALTIMORE</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>1232 Lafayette Ave</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH <u>Sept 26, 1908</u> | | 9. AGE (In years last birthday) <u>57</u> | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC LABORER (MAID) - Private Home</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>Benjamin Morgan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Brooden</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Margaret O. Wilson</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | | | |
| | | | | (B) DUE TO | | | | | |
| | | | | (C) DUE TO | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>Cerebrovascular accident</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>SEPTEMBER 12, 1966</u> to <u>SEPTEMBER 13, 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>SEPTEMBER 13, 1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>James W. Cartwright Jr.</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | 23B. DATE SIGNED <u>9/13/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY JR.</u> | | | | | | | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/16/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>MOUNT AUBURN Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u> | | 25C. FUNERAL DIRECTOR <u>HERBERT E. NUTTER</u> | | ADDRESS <u>3035 W. NORTH AVE</u> | | | |

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N.Y.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

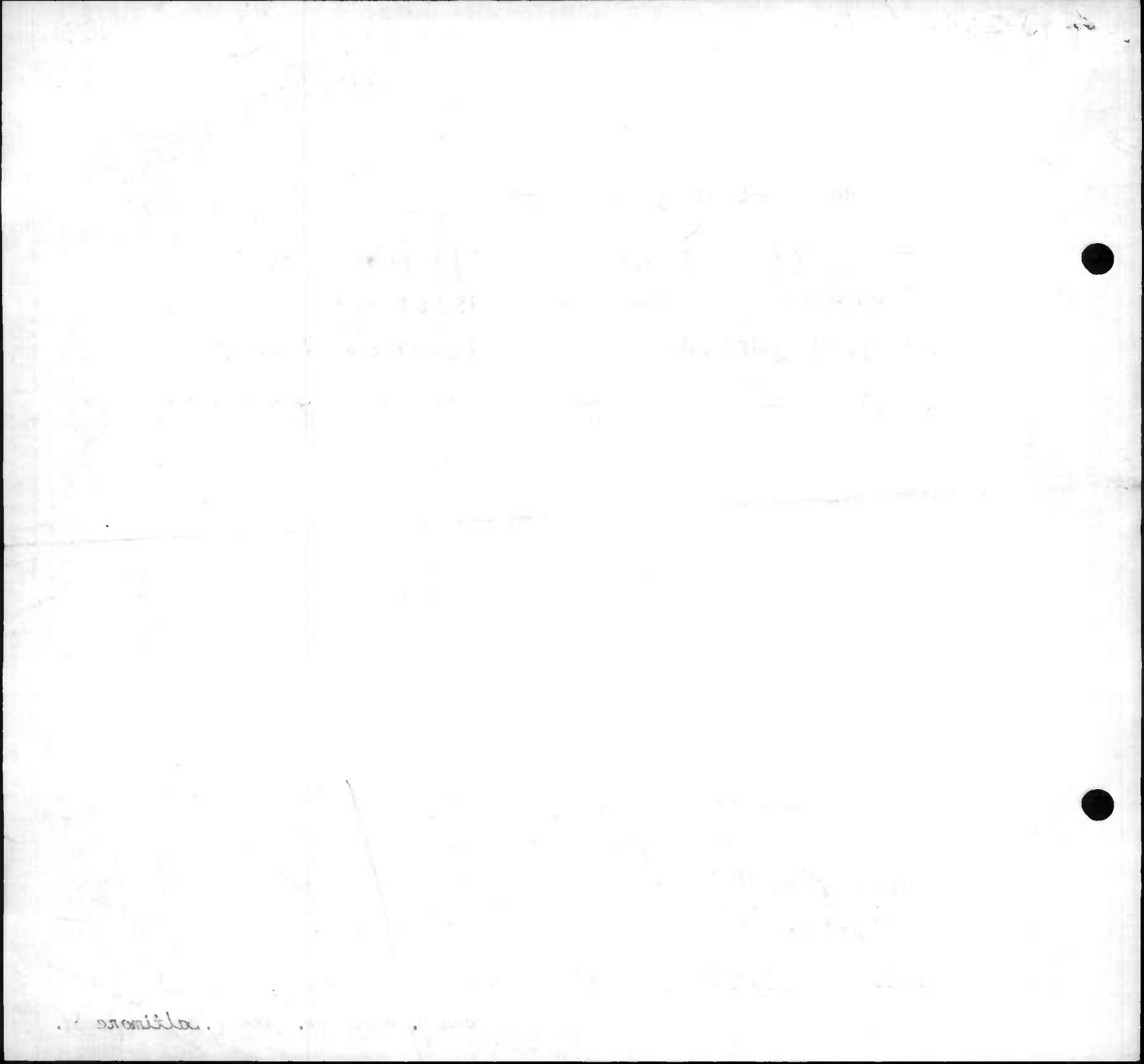
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09431</u> | |
|--|---------------------------|--|--|---|--|
| BIRTH NO. <u>66 09431</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Inez B. Johnson</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>September 15, 1966</u> <u>1: A</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>842 N. Carey Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Colored</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Oct. 13, 1904</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Public School</u> | | 11. BIRTHPLACE (State or foreign country) <u>Keysville Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Charles Thomas Mason</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Jennie Bouldin</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>214-24-0271</u> | | | |
| 16. SOCIAL SECURITY NO. <u>214-24-0271</u> | | 17. INFORMANT <u>Earl E. Johnson-842 N. Carey Street</u> | | | |
| 18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>One minute</u> <u>11 years +</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Retroperitoneal fibrosis</u> | | | | <u>5 years</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>55</u> to <u>Sept 15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>August 1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alan Bernstein</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/15/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALAN BERNSTEIN</u> | | 23D. ADDRESS <u>819 Park Ave Baltimore Md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/19/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | |
| 24D. LOCATION <u>Baltimore Co. Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Herbert E. Nutter -3035 W. North Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

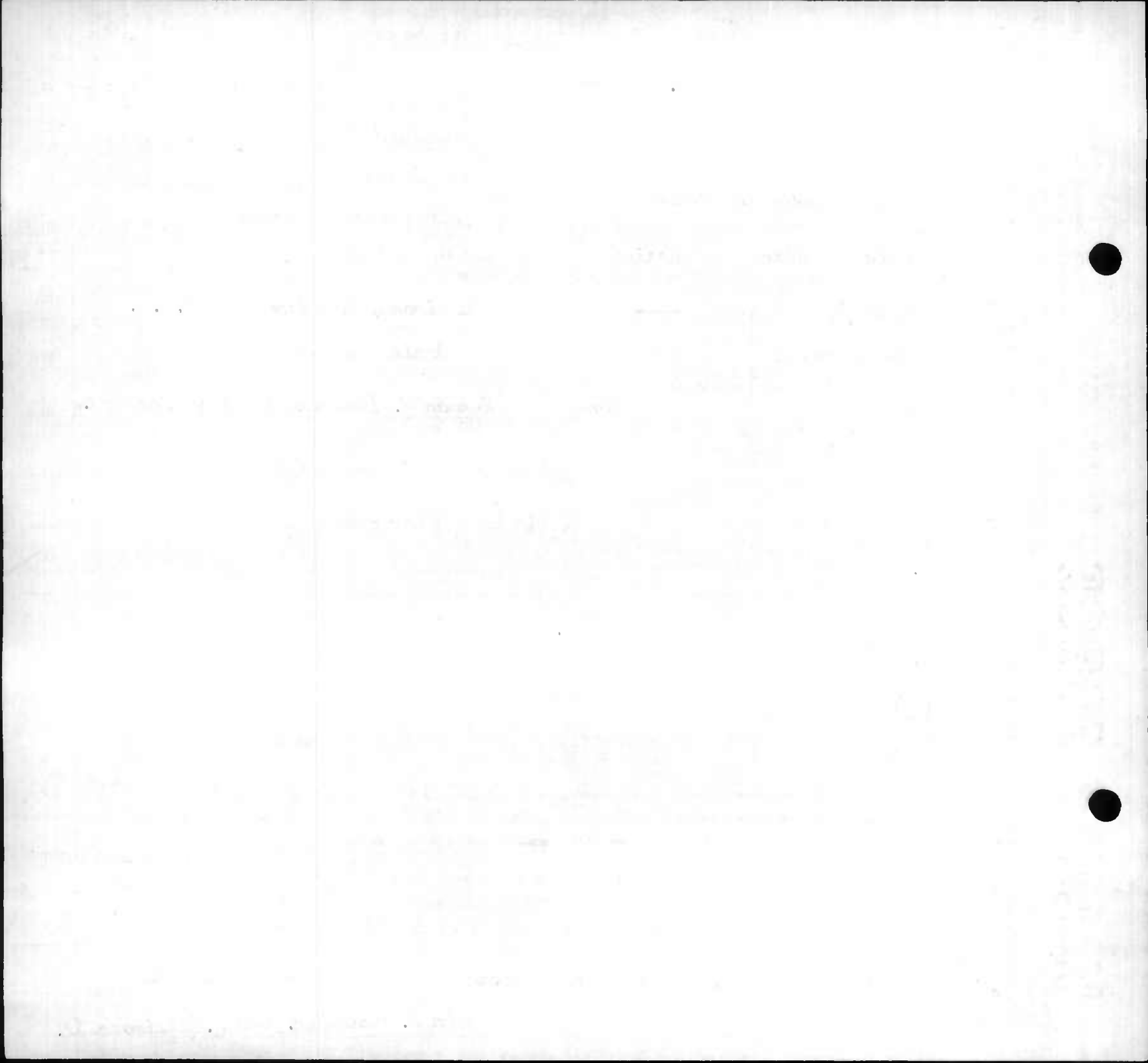
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09432 | |
|--|-------------------------------|--|--|---|--|
| BIRTH NO. 66 09432 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) DIANE JACKSON | | | | 9/16/66 5:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE | | | | A. STATE MD. B. COUNTY BALTE | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location) 1650 RIVERWOOD DRIVE | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N.M. | 8. DATE OF BIRTH 8/11/56 | 9. AGE (In years last birthday) 10 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME FRANCIS JACKSON | | | 14. MOTHER'S MAIDEN NAME DOLORES LULIE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS MOTHER - AS IN #4 ABOVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PNEUMONIA | | | | INTERVAL BETWEEN ONSET AND DEATH 2 WKS. | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) BRAIN STEM TUMOR 2 YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/15 19 66 to 9/16 19 66, that (I) (we) last saw the deceased alive on 9/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sheldon M. Frank M.D. | | | | 23B. DATE SIGNED 9/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) Sheldon M. Frank | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/19/1966 | 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR R. E. Taylor | 25C. FUNERAL DIRECTOR ADDRESS John A. Moran Inc. 3000 E. Baltimore St. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

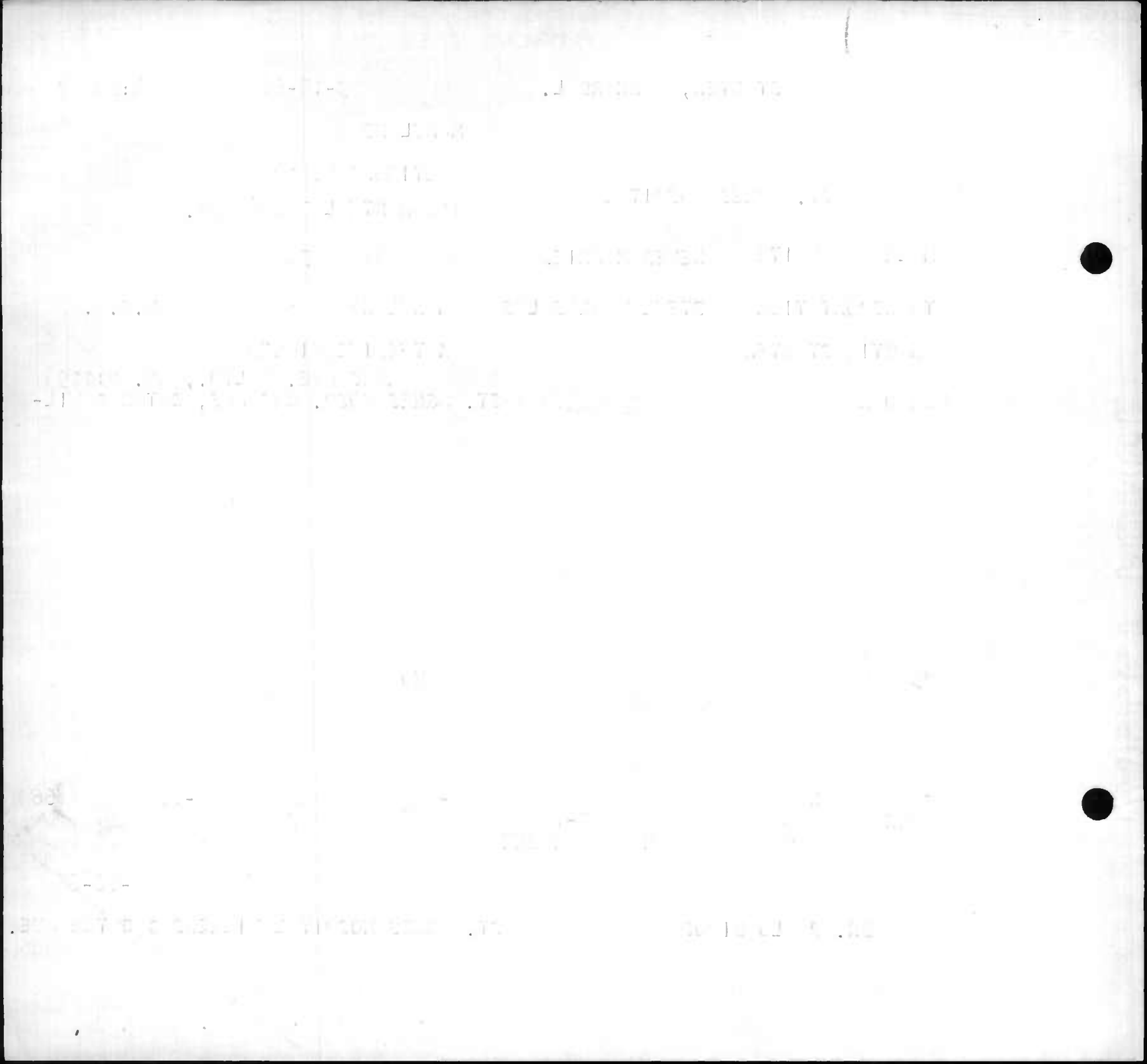
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 66 09433 | |
|---|------------------|--|--------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. 66 09433 | |
| BIRTH NO. 66 09433 | | 2. DATE AND HOUR OF DEATH September 17, 1966 11:45 A.M. | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Gertrude A. Luebeck | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3428 Leventon Avenue | | (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3428 Leventon Avenue | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/26/1892 | 9. AGE (in years) lost birthday 73 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME George Gundel | | 14. MOTHER'S MAIDEN NAME Annie unknown | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Herman H. Luebeck 3428 Leventon Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 722.1 + 15-1X Arteriosclerotic C.V.D. | | CAUSE OF DEATH (A) Arteriosclerotic C.V.D. DUE TO (B) Arteriosclerosis DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1942 to Sept. 17, 1966, that (I) (we) lost saw the deceased olive on Sept. 12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John Costantini | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN COSTANTINI | | 23D. ADDRESS M.D. 2343 CONKLING ST. BALTO., MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/1966 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Edw. E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR John A. Moran Inc. 3000 E. Baltimore St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 66 09434 | | 66 09434 | |
| BIRTH NO. | | M.E. CASE NO. | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| STADTER, BERNARD L. | | | 9-18-66 4:30 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | A. STATE MARYLAND | | |
| | | | B. COUNTY 6-02 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21224 | | |
| | | | D. STREET ADDRESS (If rural, give location) 128 NORTH LUZERNE AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 6/10/ 08 | 9. AGE (In years last birthday) 58 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSPORTATION | | 10B. KIND OF BUSINESS OR INDUSTRY STEEL WHOLESALERS | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME MARTIN STADTER | | | |
| 14. MOTHER'S MAIDEN NAME KATHERINE FIDLER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | |
| 16. SOCIAL SECURITY NO. 212-018806 | | 17. INFORMANT KENS AVE. BALTO., MD 21229 ST. AGNES HOSP. RECORDS, CATON & WIL- | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I CAUSE OF DEATH (A) Intracerebral hemorrhage DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C) disease. INTERVAL BETWEEN ONSET AND DEATH | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-18-66 to 9-18-66. that (X) (we) last saw the deceased alive on 9-18-66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Pablo F. Dibos</i> | | | | 23B. DATE SIGNED 9-18-66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. PABLO DIBOS | | | | 23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fidler, M.D. | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. | | | |



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5-425

66 09435

BALTIMORE CITY HEALTH DEPARTMENT

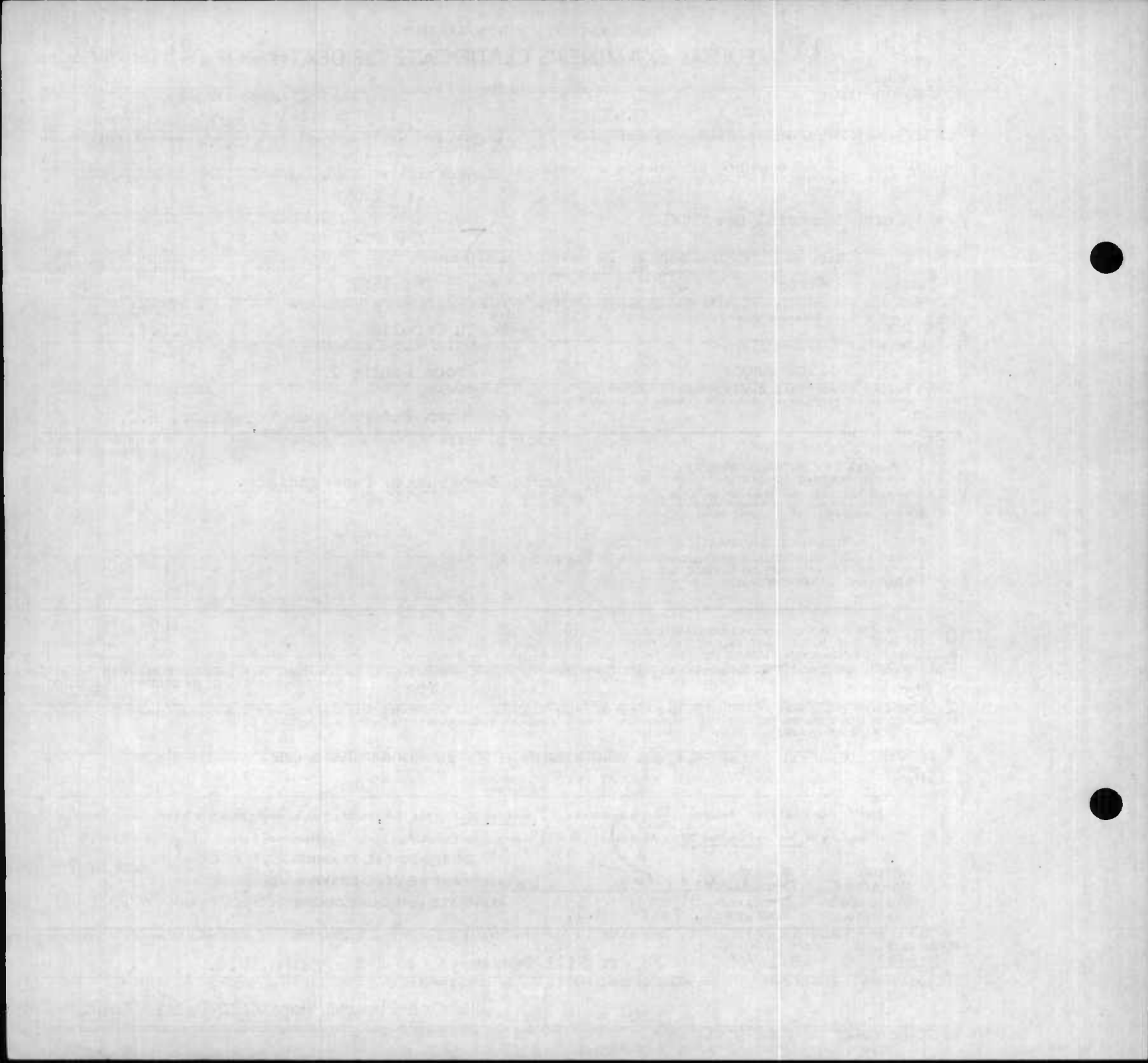
66 09435

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

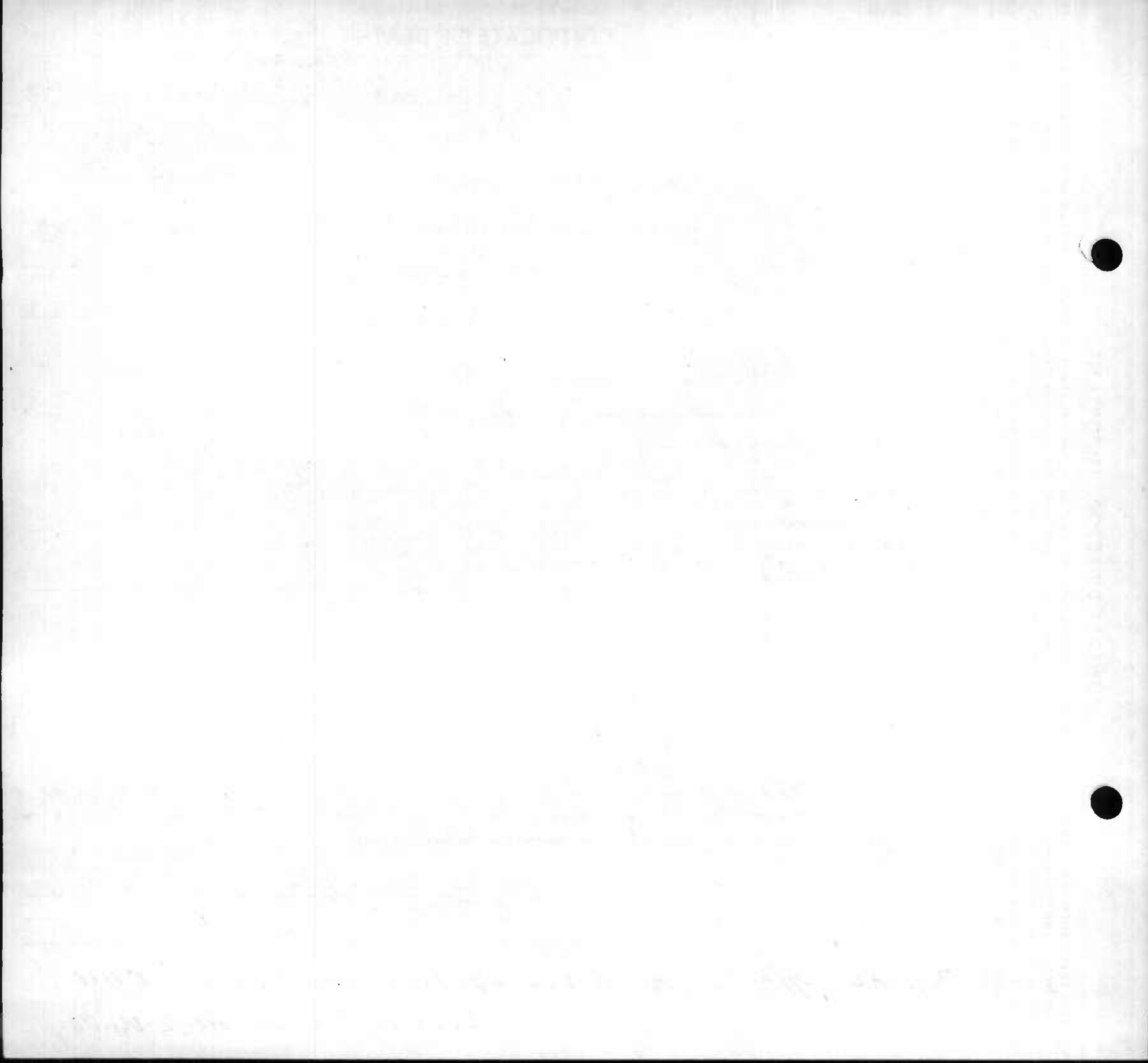
| | | | | | |
|--|------------------|---|------------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) | | ERA SLACUM | | 2. DATE AND HOUR PRONOUNCED DEAD September 14, 1966 5:00 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | A. STATE Maryland | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2730 St. Paul Street | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 26, 1927 | 9. AGE (In years last birthday) 39 | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Patrick Mooney | | 14. MOTHER'S MAIDEN NAME Grace Louise ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sossoman Funeral Home Morganton, N.C. | |
| 18. 5-87.0 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Acute Hemorrhagic Pancreatitis. DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/15/66 | |
| M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/15/66 | | 23C. NAME of CEMETERY or CREMATORY Forest Hill Cemetery | |
| 23D. LOCATION (City, town, or county) (State) Morganton, N.C. | | | | | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. | |
| 24D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

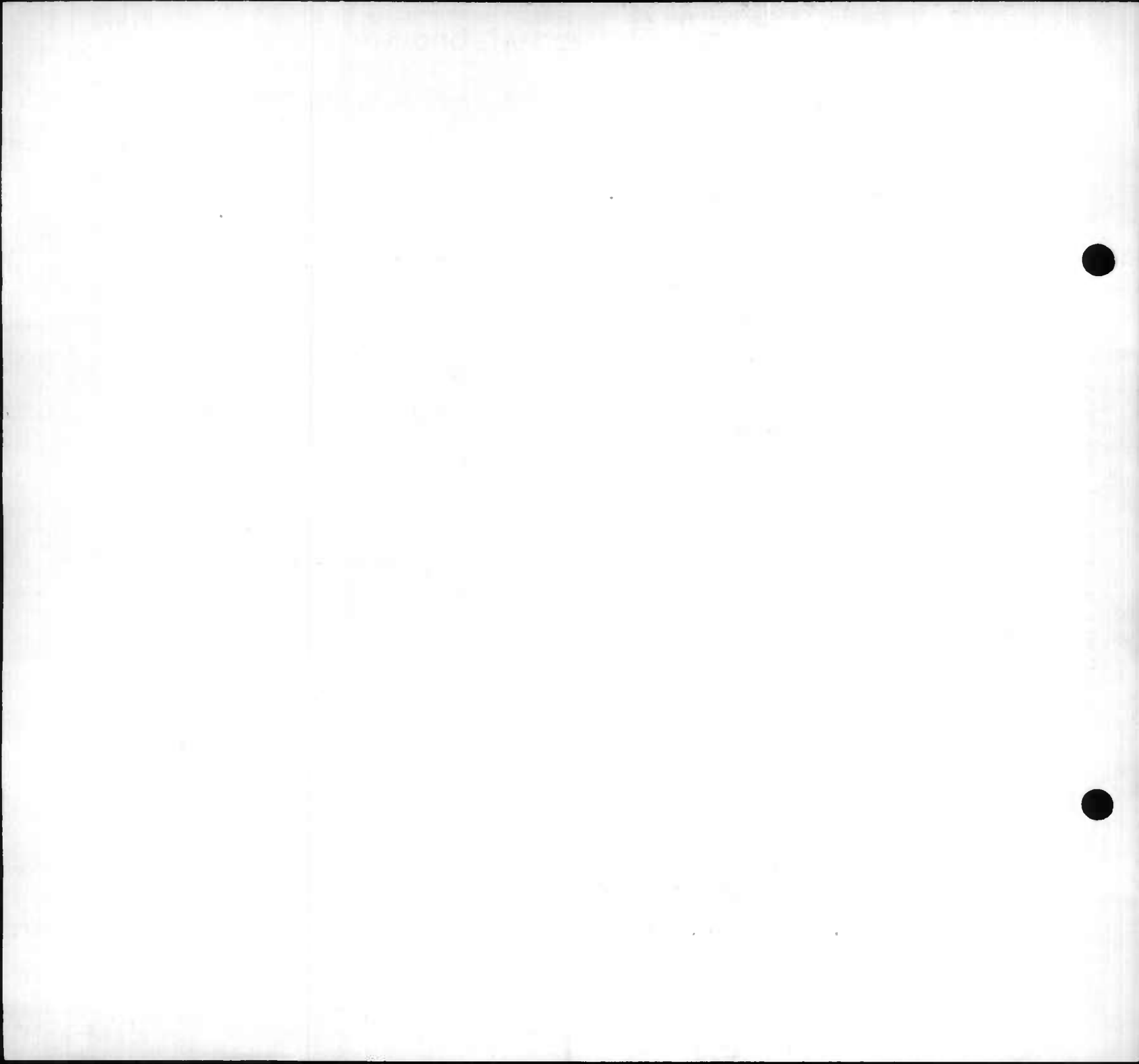
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------|--|---|--|--------------------------------|
| 66 09436 | | CITY HEALTH DEPARTMENT | | 66 09436 | |
| M.E. CASE NO. | | CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Henry A. Kuhn | | 9-15-1966 11:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| North Charles General Hospital | | Maryland Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore Zone 21222 5300 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 41 York Way | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Male | White | Married | 4-4-1899 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Retired WELDER | | SHIP YARD | Ohio | | U.S.A |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Andrew Kuhn | | | Bertha Gillie | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| yes | | 219-05-0407 | Eunice F. Kuhn 41 York Way Balto. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Lung Cancer, undifferentiated | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (this hospital) attended the deceased from September 5, 1966 to September 15, 1966, that (I) lost saw the deceased alive on September 15, 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| A. Gelpira | | | | September 15, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | North Charles General Hospital Char. 28th | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 9/19/66 | | ZANESVILLE MEMORIAL ZANESVILLE OHIO | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | SEP 20 1966 | | ULLRICH FUNERAL HOME-DUNDALK MD | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09437 | |
|---|-------------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 09437</p> <p>M.E. CASE NO.</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>X</p> </div> </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) MICHAEL MARTIN | | | 2. DATE AND HOUR OF DEATH 9/15/66 1:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-52 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21 D. STREET ADDRESS (If rural, give location) 1615 INVERNESS AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD | 8. DATE OF BIRTH 5-19-66 | 9. AGE (In years last birthday) 4 MONTHS | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME GEORGE MARTIN | | | 14. MOTHER'S MAIDEN NAME DORA THOMAS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS George Martin, 1615 Inverness Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 256.210571.0 CAUSE OF DEATH ? <i>Marine</i> GI hemorrhage (A) DUE TO Enter colitis (B) DUE TO Hemorrhagic disease (C) DUE TO From birth | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour (?) 1 week From birth | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypoproteinemia, Thrombocytopenia</p> | | | | | |
| 19A. DATE OF OPERATION 3/10/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction | | 20A. AUTOPSY? (Yes or No) Pending YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 19 66 to 9/15 19 66 , that (I) (we) last saw the deceased alive on 9/15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Timothy J. Gardner M.D. | | | | 23B. DATE SIGNED 9/15/66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. TIMOTHY J. GARDNER | | 23D. ADDRESS 1537 E. Monument St. Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/66 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Colgate, Md/ | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR SEP 20 1966 | | 25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md. | | | |

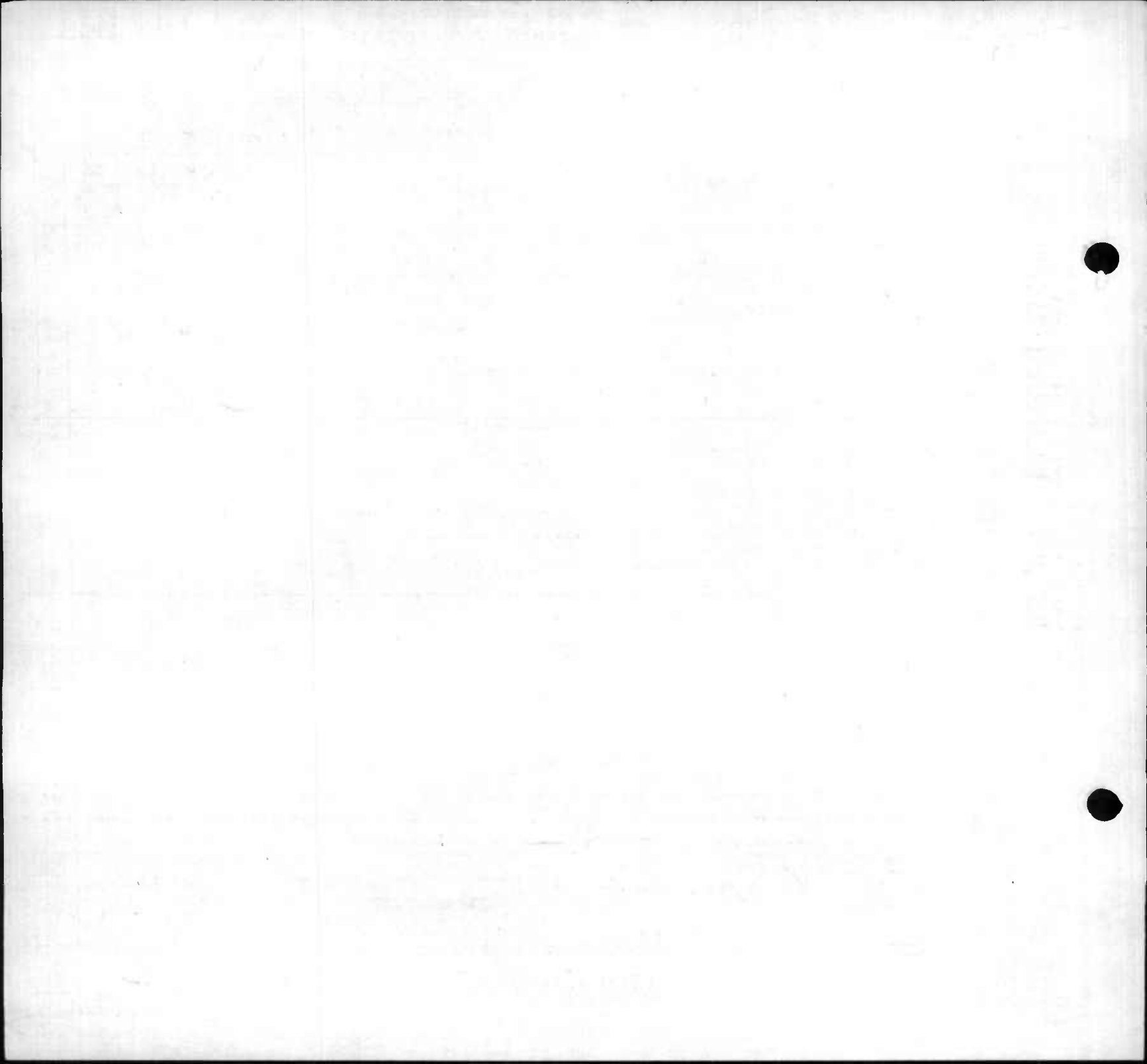


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|---|------------------|--|---------------------------------|
| 66 09438 | | CERTIFICATE OF DEATH | | 66 09438 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ANDRE FRANKLIN | | 9/12/66 1:55 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| UNIVERSITY HOSPITAL | | MARYLAND. BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | OWINGS MILLS MARYLAND | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | RISTENY TOWN RD - OWINGS MILLS M.D. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | NEGRO | NEVER MARRIED | 6/16/60 | 6 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RESIDENT ROSEWOOD | | NONE | | WASHINGTON D.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| ANDREW FRANKLIN | | SYLVIA TAYLOR - LUCILLE FRANKLIN JACKSON | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | SEITLER M.D. | |
| | | | | ADDRESS CAPITAL HEIGHTS 925-2796 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) PERITONITIS Generalized DUE TO Perforation Bowel (Foreign Body) | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 9/9/66 | | FOREIGN BODY - BOWELS | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NONE | | NONE | | NONE | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| NONE | | | | NONE | |
| 22. I certify that (this hospital) attended the deceased from 9/9/66 to 9/12/66, that (we) lost saw the deceased alive on 9/9/66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (view) the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Brent C. Sanders M.D. | | | | 9/12/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| BRENT C. SANDERS | | | | 137 NORTH BEND ROAD 2C BALTIMORE MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | 9-19-66 | | Arlington Nat | |
| | | 24D. LOCATION (City, town, or county) | | (State) | |
| | | Arlington Va | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | H. S. WASHINGTON AND SONS | | ADDRESS DEANE AVENUE WASHINGTON N.E. | |

SEP 20 1966



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 09439 | |
|--|---------------|--|--------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 66 09439 | | | | 2. DATE AND HOUR OF DEATH | | 9-15-66 3:00 P.M. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | LEO N. PEKAR | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE MARYLAND B. COUNTY 25-31 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| 44 UNION MEMORIAL HOSPITAL | | | | D. STREET ADDRESS (If rural, give location) | | 434 RANDOM RD. | |
| 5. SEX M | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPA SINGLE | 8. DATE OF BIRTH 2-20-99 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| CHIEF IVINE STEWART | | HOTEL | | BOLINGBROOK MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| MICHAEL PEKAR | | | | CECILIA CZARSKI | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | | | Michael Esler 434 Random Road. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) COMPLETE HEART BLOCK | | | |
| ANTECEDENT CAUSES | | | | (B) MYOCARDIAL INFARCTION | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO EXTREMOSCLEROTIC CV DISEASE | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | 9-15-66 | |
| EDUBERTO G. GOZO, JR. | | | | UNION MEMORIAL HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9-19-66 | | St. Stanislaus Cem. | | Bldg. Ind | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |

23.53.3 2/2

23.53.3 2/2

23.53.3 2/2

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23.53.3 2/2

23.53.3 2/2

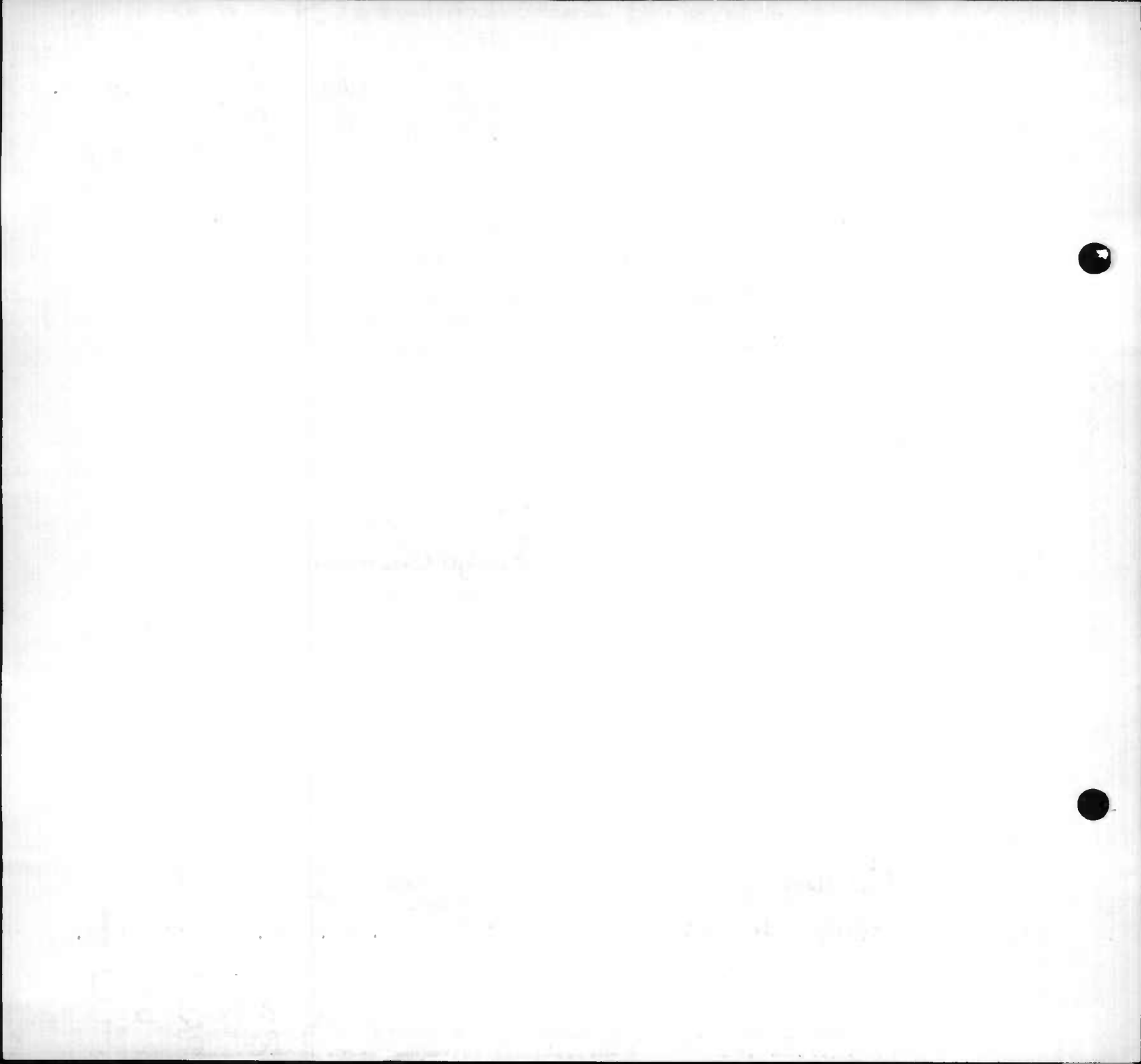
23.53.3 2/2

23.53.3 2/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|------------------|--|----------------------------------|
| 66 09440 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09440 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Anton Uhl | | 9/18/66 11:40 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | | |
| South Baltimore General Hospital | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1302 Andre Street Balto. City | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| Male | White | Married | 3/23/1894 | 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Dr. of Highways | | Hungary | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Nicholas Uhl | | Leaga | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Family - Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Left lower lobe pneumonia & bronchi- | | | |
| | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) Gastrointestinal bleeding | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) Generalized arteriosclerosis | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from 9/14/66 to 9/18/66 that (we) last saw the deceased alive on 9/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| R. G. Arellano | | | | 9/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ROBERTO G. ARELLANO | | | | South Balto. Gen. Hosp. - 1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| B | | 9/24/66 | | Garden of Faith | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 20 1966 | | A. D. E. E. E. | | 1400 E. 130 E. FORT AVE - 30 | |



B-652

66 09441

BALTIMORE CITY HEALTH DEPARTMENT

66 09441

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS L. BERNHARD

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966 7:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

436 Grindall Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

436 Grindall Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 3, 1912

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Watchmen

10B. KIND OF BUSINESS OR INDUSTRY

Paint Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Joseph Bernhard

14. MOTHER'S MAIDEN NAME

Unknown Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Rosemary Bernhard

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9 21 1966

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Mc Cully

130 E. Fort Ave.

WALLEY BOWLING

MA BOWLING

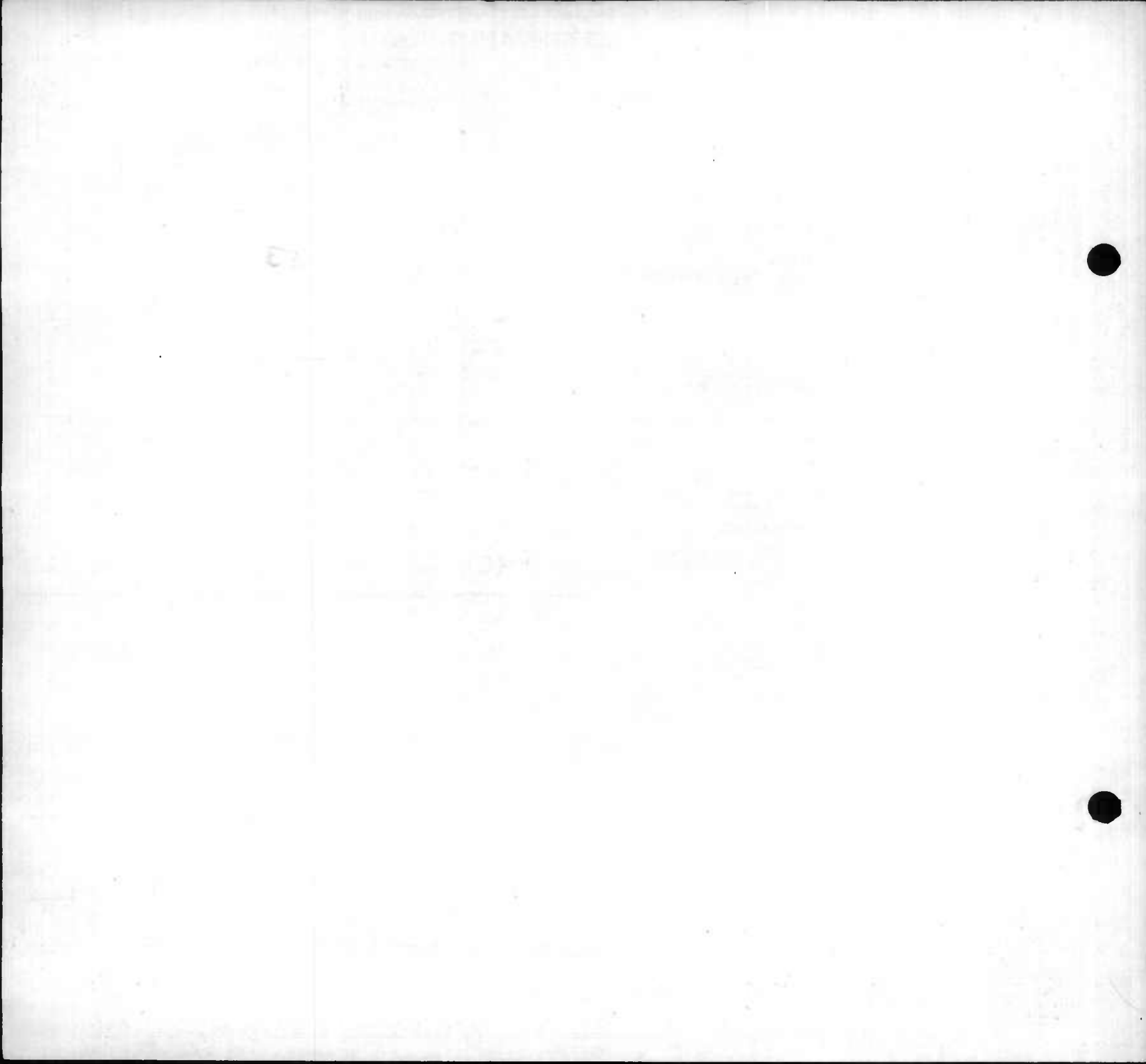
1954

5

FUNERAL DIRECTOR: IMPORTANT

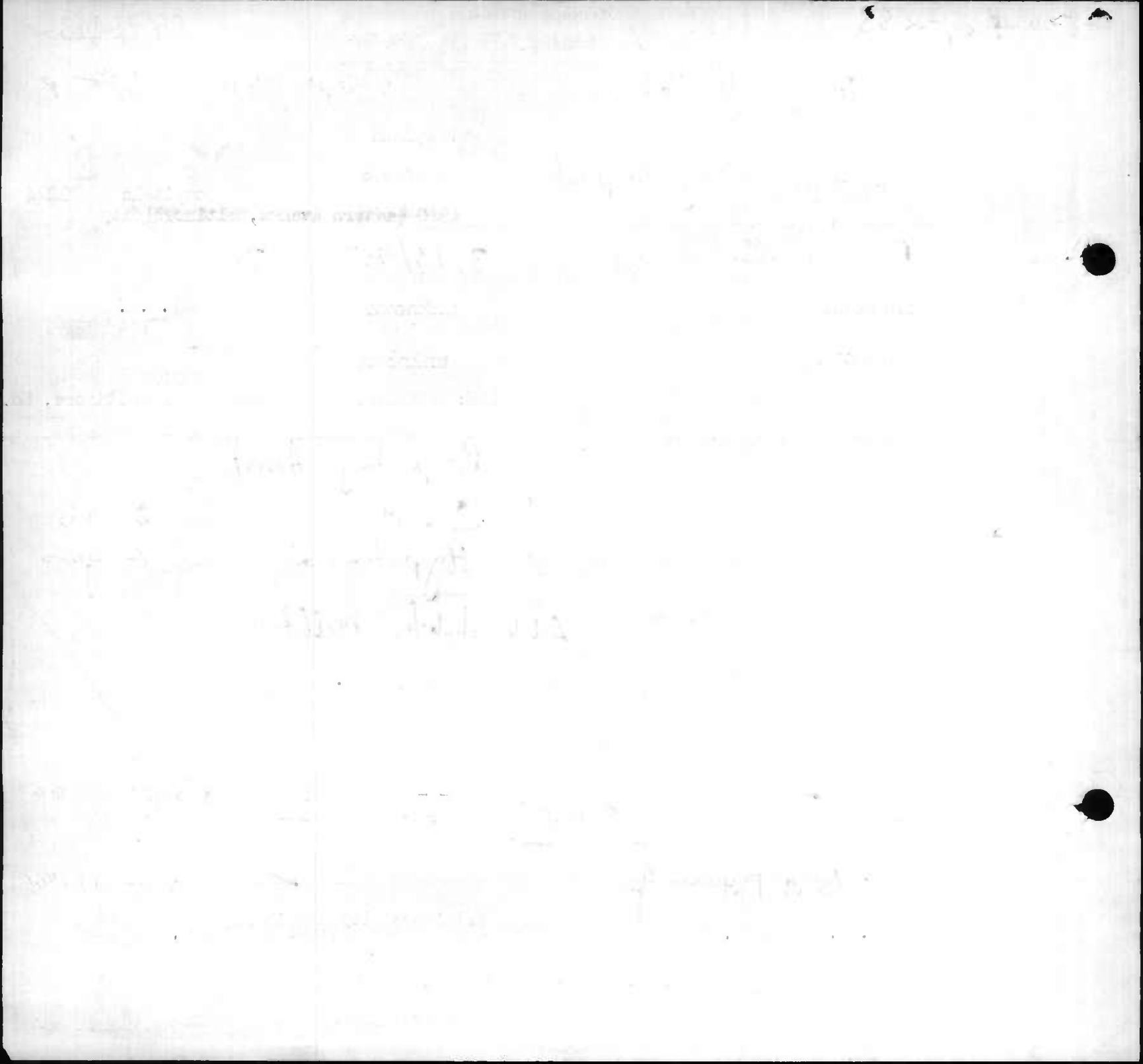
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09442 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09442 | |
|---|------------------------|---|---|--|--|--|---------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Antoinette M. Cerniglia</i> | | 2. DATE AND HOUR OF DEATH <i>9/18/66</i> <i>8:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>21-02</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1303 James Street. (23)</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Cauc</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>11/25/12</i> | | 9. AGE (In years last birthday) <i>53</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 13. FATHER'S NAME <i>Dominic Cerniglia</i> | | | 14. MOTHER'S MAIDEN NAME <i>Elvira Cerniglia Serio</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Family (above)</i> | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Peritonitis 2° Perforated Ulcer</i> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>4 Days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO <i>Septic Shock 2° A.</i> | | <i>2 Days</i> | |
| | | | | (B) DUE TO <i>Acute Renal Failure</i> | | <i>24 hr.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>9/14/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Perforated Ulcer</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/14</i> 19 <i>66</i> to <i>9/18</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/18</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Thomas M. Hudak</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/18/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Thomas M. Hudak</i> | | | | 23D. ADDRESS <i>University Hosp. Bldg. Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/22/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Green Battered</i> | | 24D. LOCATION (City, town, or county) (State) <i>Belts. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>John J. Cowan</i> | | 25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i> | | ADDRESS <i>901 Hollins St. Balto 03, Md.</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

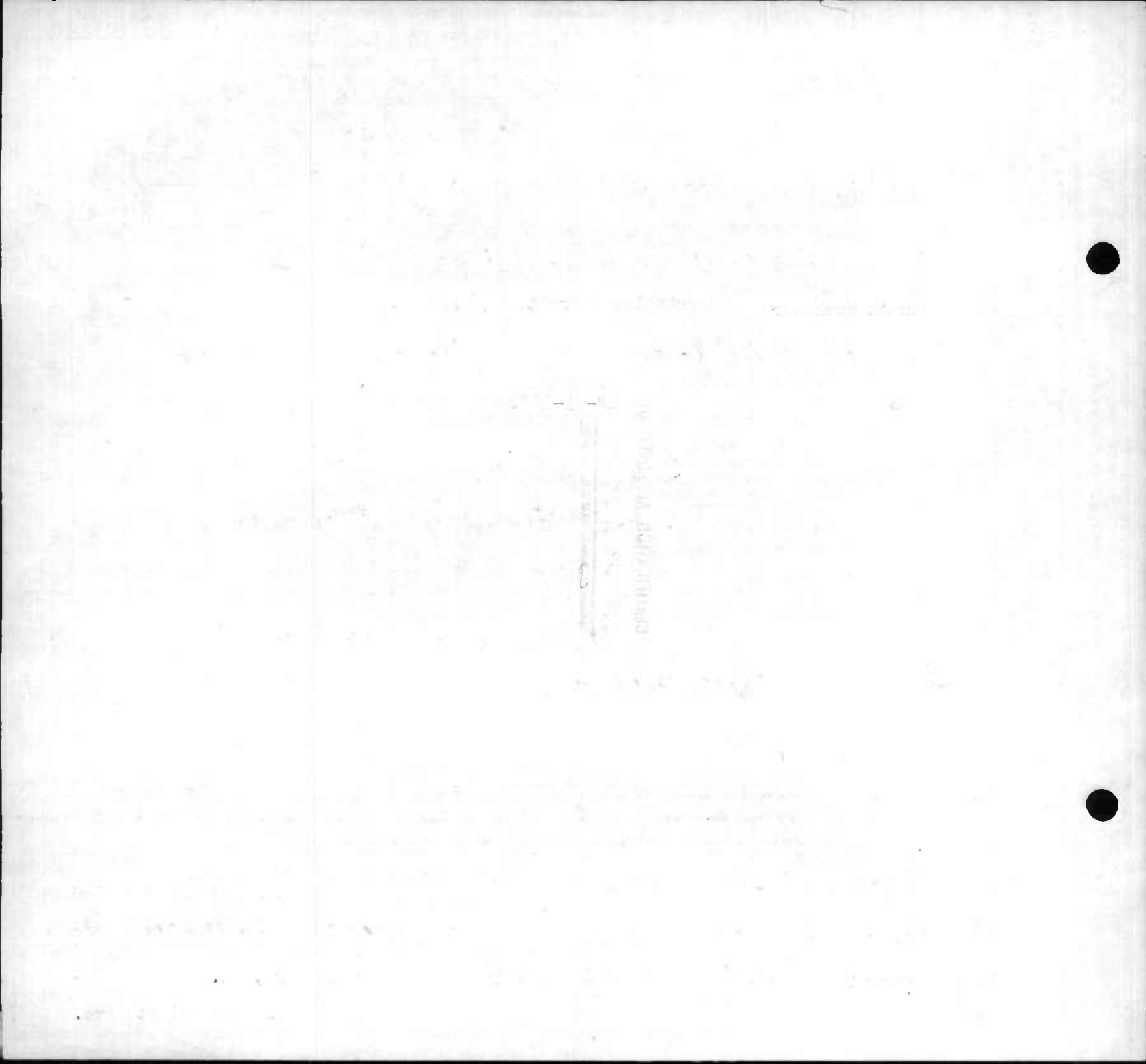
| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|-----------------------------|--|
| BIRTH NO. | | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Mary McMahon | | | | | | 5 Sept 1966 6 ¹⁰ P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | Maryland | | | | | |
| 4940 Eastern Avenue Baltimore, Maryland # 21224 | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) Hospitals 21224 4940 Eastern Avenue, Baltimore City | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. Under 1 Yr. Months Days | |
| Female | | White Caucasian | | Married | | 3/13/95 | | 71 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| unknown | | | | | | | | unknown | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| unknown | | | | | | unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | | | | |
| NO | | | | | | # 21224 ADDRESS | | | | | |
| | | | | | | BCH: RECORDS 4940 Eastern Avenue Baltimore, Md. | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) DUE TO Respiratory Arrest | | | | | |
| ANTECEDENT CAUSES | | | | | | (B) DUE TO CVA | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (C) Hypertension | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | Labile diabetes mellitus | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 0 | | | | | | | | 2 weeks | | 6 years | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 1-3-19 65 to 5 sept 19 66, that (H) (we) last saw the deceased alive on 5 Sept 19 66 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE DA Raine Jr. | | | | | | 23B. DATE SIGNED 5 Sept 1966 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) D. A. Raine Jr. | | | | | | 23D. ADDRESS Baltimore City Hospitals # 21224 4940 Eastern Avenue Baltimore, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | 24E. ADDRESS | | | |
| Burial | | 9-19-66 | | Sacred Heart Cemetery | | Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| | | | | | | | | Walter Zakowski 1005 Denmark dr. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------------|--|---|
| 66 09444 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09444 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Leo M^s Gee | | 2. DATE AND HOUR OF DEATH 9-15-66 7:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-16 D. STREET ADDRESS (If rural, give location) 4415 1/2 Park Heights Avenue | | | |
| 5. SEX M | 6. RACE CAUC. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 8-5-1894 | 9. AGE (In years last birthday) 73 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster | | 10B. KIND OF BUSINESS OR INDUSTRY Vegetables & Fruit | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | |
| 13. FATHER'S NAME Michael M^s Gee | | 14. MOTHER'S MAIDEN NAME Helen Heffner | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-05-6672 | | 17. INFORMANT HOSP. REC. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Respiratory Insufficiency | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 9-15-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypochlohydria | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-1-1966 to 9-15-1966 , that (I) (we) last saw the deceased alive on 9-15-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank L. Barham | | | | 23B. DATE SIGNED 9-16-66 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK L. BARHAM | | 23D. ADDRESS M.D. Mercy Hospital Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR W. Vernon Lennon | | ADDRESS 4611 Park Heights Ave. | |



L-516

66 09445

BALTIMORE CITY HEALTH DEPARTMENT

66 09445

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) ANNA FRANCES LAMBERT | | 2. DATE AND HOUR PRONOUNCED DEAD September 16, 1966 5:15 P | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Franklin Square Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 1245 Washington Boulevard | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH October 15, 1894 |
| | | | 9. AGE (In years last birthday) 71 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant & Hotel Worker | | 11. BIRTHPLACE (State or foreign country) Petersburg, West Virginia | |
| 13. FATHER'S NAME John Landis | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-18-2853A | |
| | | 17. INFORMANT Edna Stewart, 1245 Washington Blve. Balto Md | |

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH Multiple Traumatic Injuries. | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO | | |
| (B) DUE TO | | |
| (C) DUE TO | | |

| | | |
|--|--|--|
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | |
|---|--|---|--|
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pratt St., W. of Carrollton Avenue | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9 16 '66 P | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? Pedestrian struck by auto. | |

| | |
|---|-------------------------------|
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE Charles S. Petty, M.D. | DATE SIGNED 9/17/66 |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |

| | | | |
|---|--|--|--|
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE Sept 19, 1966 | 23C. NAME OF CEMETERY or CREMATORY Sunset Memorial Park | 23D. LOCATION (City, town, or county) (State) Near Cumberland, Md. |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | 24B. NAME OF REGISTRAR John J. Hafer | 24C. FUNERAL DIRECTOR John J. Hafer, 230 Balto Ave., Cumberland Md | |

1
H-512

66 09446

BALTIMORE CITY HEALTH DEPARTMENT

66 09446

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA E. Heinbuch

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1966 9:42 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7718 Philadelphia Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-17-1881

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Selfemployed

10B. KIND OF BUSINESS OR INDUSTRY

Florist

11. BIRTHPLACE (State or foreign country)

Rossville, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Weinreich

14. MOTHER'S MAIDEN NAME

Mary Kern

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-26-3052A

17. INFORMANT

ADDRESS

Mrs Minnie Walsh 7718 Philadelphia Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary Embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Deep Leg Vein Thrombosis
DUE TO

(C) Fracture of Right Tibia.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Sanford, Florida

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

'66

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fall on street.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
9/17/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-1966

23C. NAME of CEMETERY or CREMATORY

Zion Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

Co.

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Robert E. Farley, M.D.

Lassahn Funeral Home 7401 Belton Road

WALTER E. DORRIS

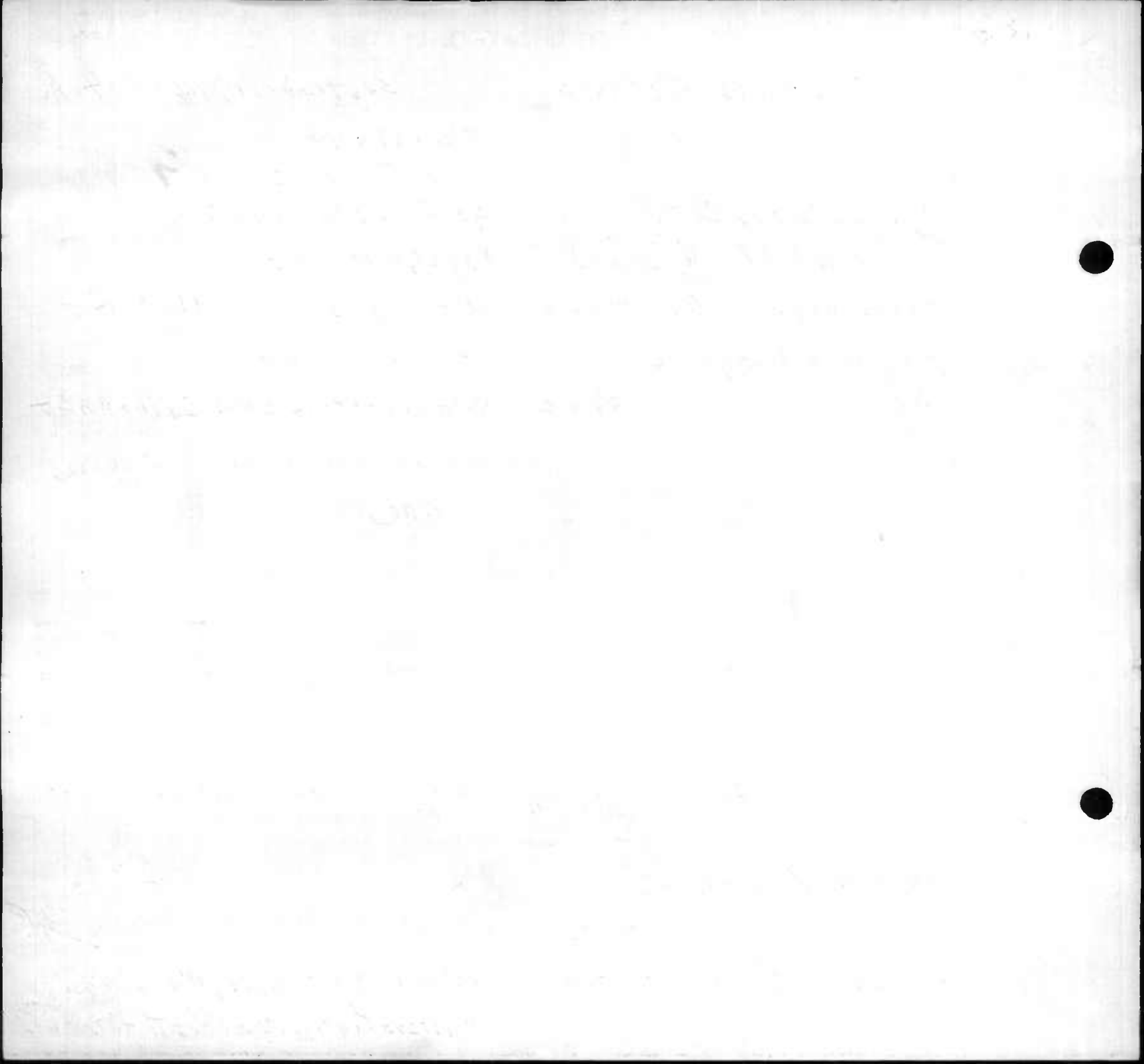
PROSECUTOR

1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

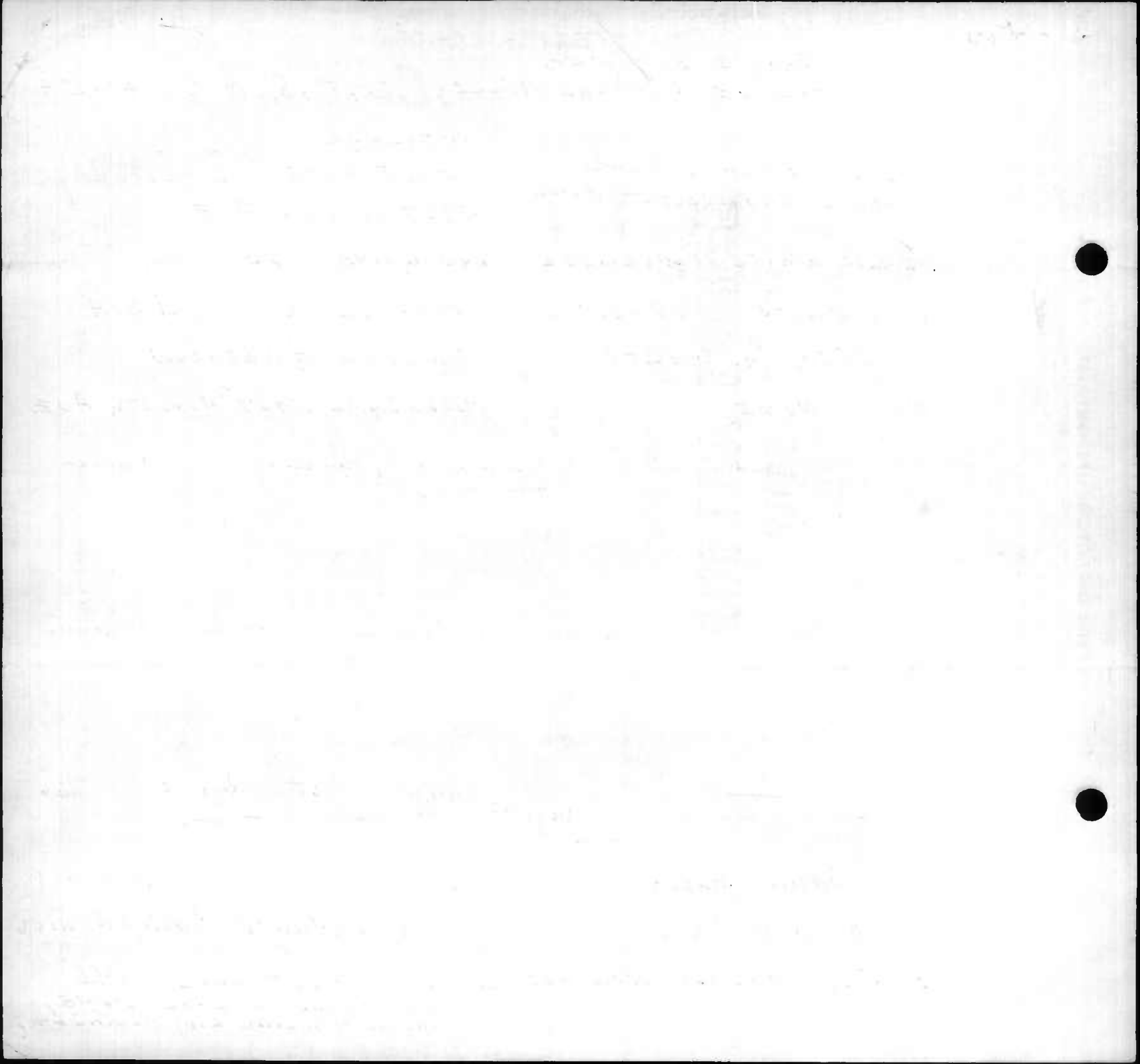
| BIRTH NO. 66 09447 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09447 | |
|---|-------------------------|---|--|--|--|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Ella Maud Jeffers</u> | | | | 2. DATE AND HOUR OF DEATH <u>September 15, 1966</u> <u>4 A.</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY | |
| <u>255 Calhoun St.</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | <u>19-03</u> | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>255 Calhoun St.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>May 28, 1973</u> | 9. AGE (In years last birthday) <u>93</u> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Augusta Musgrove</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Cobb</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Roland Jeffers</u> | | ADDRESS <u>255 Calhoun St.</u> | |
| 18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Artery Disease</u> | | | | CAUSE OF DEATH (A) DUE TO <u>Age</u> (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>Sept. 15</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15</u> 19 <u>66</u> to <u>Sept. 15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept. 14</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Morris B. Schreiber</u> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9-16-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>MORRIS B. SCHREIBER</u> | | | | 23D. ADDRESS <u>1579 N. Lombard St. Baltimore Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/19/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert S. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Walters Funeral Home Pratt & Stricker</u> | | ADDRESS <u>545</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09448 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09448 | |
|---|-------------------------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CARRIE B. MILLER CAROLINE BLANCHE MILLER | | | 2. DATE AND HOUR OF DEATH SEPT. 18, 1966 4:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 6116 BELAIR Road. Gould Convalescent Home | | | A. STATE MARYLAND B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-01 | | |
| | | | D. STREET ADDRESS (If rural, give location) 5927 MARLUTH AVE. | | |
| 5. SEX FEMALE | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH JAN. 16, 1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME PETER J. WOLFE | | | 14. MOTHER'S MAIDEN NAME ROSSELLA Anderson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. ? NONE | 17. INFORMANT ADDRESS MELBA SMITH 5927 MARLUTH AVE. | | |
| 18. 160.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coronary of diseases DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 years | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Arteriosclerotic Cardiovascular Disease 10 years | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 14, 1965 to Sept. 18, 1966 , that (I) (we) last saw the deceased alive on Aug. 23, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Adam G. Swiss | | | | 23B. DATE SIGNED Sept. 19, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) ADAM G. SWISS | | | 23D. ADDRESS 6132 Belair Rd. Balt., Md 21206 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-21-66 | 24C. NAME OF CEMETERY OR CREMATORY NEW Cathedral | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Sisk | | 25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home Francis H. Miller 2101 Redbank Ave | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

GEORGE

HATTEN

2. DATE AND HOUR PRONOUNCED DEAD

September 15, 1966

8:45 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

11-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5 W. Biddle Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

3/18/14

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

George Hatton

14. MOTHER'S MAIDEN NAME

Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W 2

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr James Hatton 1012 Druid Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Right Subdural Hematoma.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Preston St. & Pennsylvania Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 13 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE AT
WORK ☒

21F. HOW DID INJURY OCCUR?

Fall on street.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
9/15/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/19/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

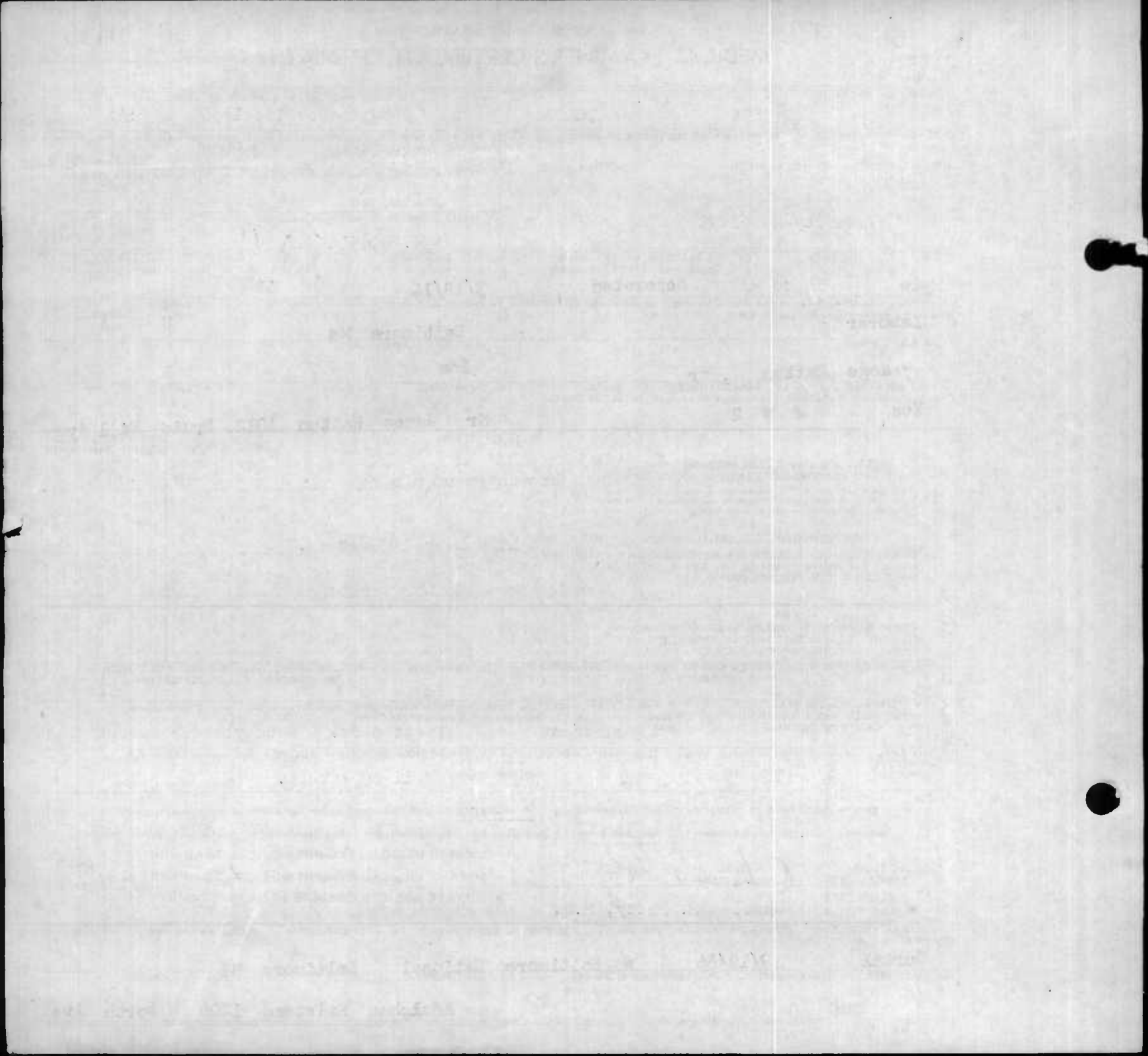
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Adolphus Halstead 1206 W North Ave



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **66 09450**

BIRTH NO.
M.E. CASE NO.

| | | | | | |
|---|---------------------------|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) Hazel McFadden | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/15/66 9:15p. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 708 W. Lafayette Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 708 W. Lafayette Ave. | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 7/13/29 | 9. AGE (in years last birthday) 37 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME Reese McFadden | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 251-44-9156 | | |
| 17. INFORMANT Mrs Elease McFadden | | | ADDRESS 708 W Lafayette Av | | |

| | | | |
|---|--|--|--|
| 18. 490X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia, right lower lobe (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty alteration of liver | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/16/66 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 9/20/66 | 23C. NAME OF CEMETERY or CREMATORY King St S.C. | 23D. LOCATION (City, town, or county) (State) |
| 24A. DATE REC'D BY HEALTH DEPT. | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR Adolphus Halstead | ADDRESS 1206 W North Ave |

SEP 20 1966

WINTER PAGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|---|------------------|--|--|
| BIRTH NO. 66 09451 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09451 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Banks Lena</i> | | 2. DATE AND HOUR OF DEATH <i>9/16/66 8:30 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>10-02</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>1224 East Madison Street</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <i>56</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>UNKNOWN</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>CRAWLEY BROTHERS</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>LOTTIE - UNKNOWN</i> | | 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. <i>218-07-8662</i> | | 17. INFORMANT ADDRESS <i>MARGARET FIELDS 1118 FORREST ST</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Intestinal obstruction & shock</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/16 1966</i> to <i>9/16 1966</i> that (I) (we) last saw the deceased alive on <i>9/16 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>David S. Fedson</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/16/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. David S. Fedson</i> | | 23D. ADDRESS <i>The Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9-21-66</i> | | 24C. NAME of CEMETERY or CREMATORY <i>MT ALBURN</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1966</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fedson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>JOSEPH KNIGHT 1639 N. BROADWAY</i> | | | |

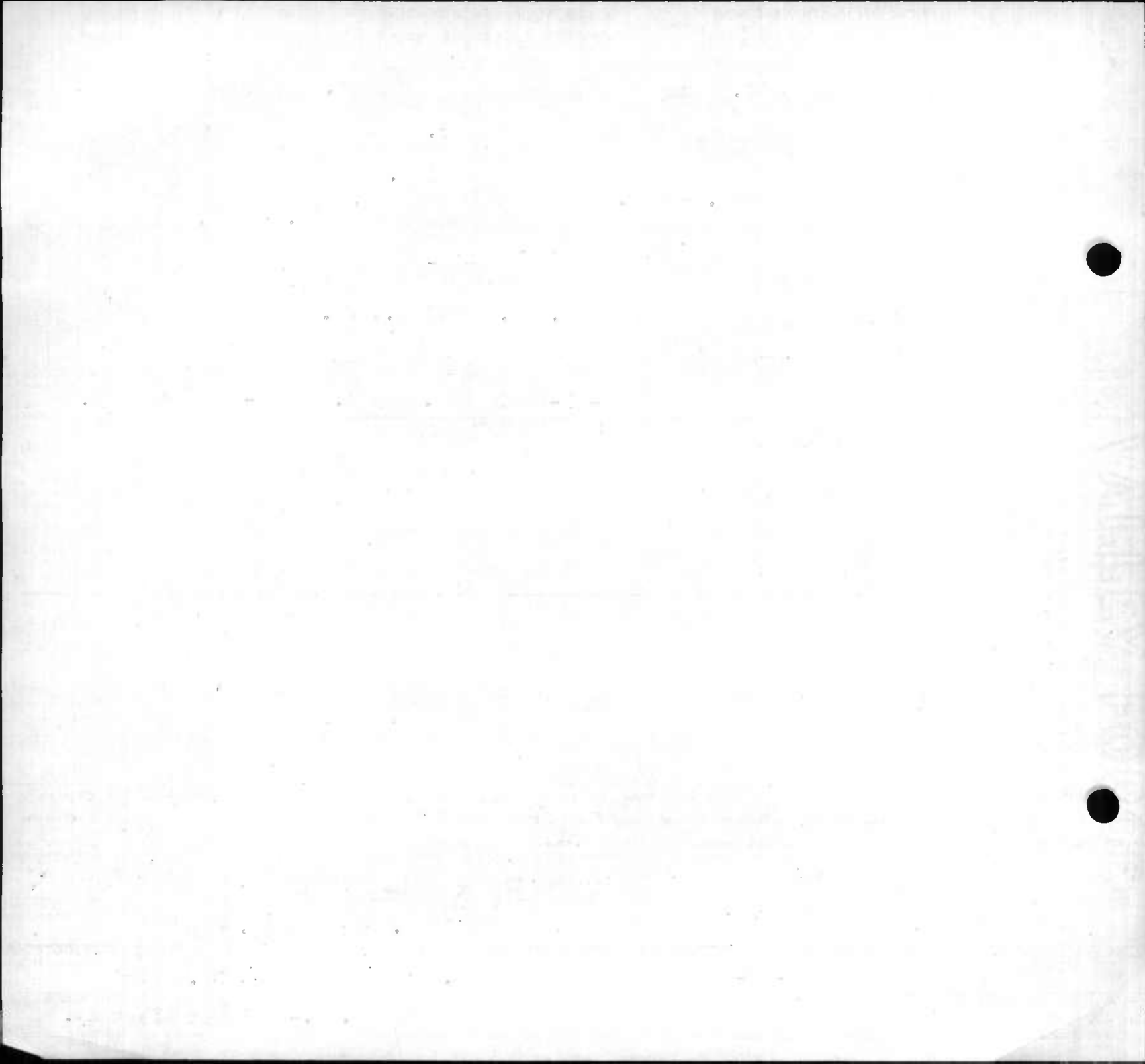
1. 1000 lbs. of the above
2. 1000 lbs. of the above
3. 1000 lbs. of the above
4. 1000 lbs. of the above

1000 lbs. of the above
1000 lbs. of the above

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09452</u> | |
|---|----------------------|---|--|--|---|
| BIRTH NO. <u>66 09452</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Eugene C. Stump</u> | | | 2. DATE AND HOUR OF DEATH <u>Sept. 17, 1966</u> <u>3 4</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>406 Athol Ave. - Apt. B</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>28-04</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>406 Athol Ave. - Apt. B</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>Wh</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>9-10-87</u> | 9. AGE (In years last birthday) <u>79</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Sun Life Ins. Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>William Stump</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Anna Hahn</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>212-01-2360A</u> | | 17. INFORMANT ADDRESS <u>Mrs. May M. Stump-406 Athol Av.</u> | | | |
| 18. <u>350X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Parkinsons Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 1950</u> to <u>September 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Morris Schreiber</u> | | | | 23B. DATE SIGNED <u>9-19-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Morris Schreiber</u> | | | | 23D. ADDRESS M.D. <u>1517 W. Lombard St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-21-66</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u> | |
| 24D. LOCATION <u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Witzke F. D.-4101 Edmondson Av.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 66 09453 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09453 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mabel Carroll | | 2. DATE AND HOUR OF DEATH 1:30 9/17/66 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Mary Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-01 | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) | |
| 8. DATE OF BIRTH 12-6-88 | | 9. AGE (In years lost birthday) 77 | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Thomas F. McNulty | |
| 14. MOTHER'S MAIDEN NAME Clara Magarity | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. E. REICHENBACH | | ADDRESS 4607 HARCOURT RD. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Uremia | | CAUSE OF DEATH Hemorrhagic cystitis | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-14-66 19 to 9-17-66 19, that (I) (we) last saw the deceased alive on 9-17-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael Rokoff | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) Michael Rokoff | | 23D. ADDRESS Mary Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/20/66 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PARK | |
| 24D. LOCATION BALTIMORE, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST. | | | |

A

12-6-88 JJ
Baltimore
CLARA MAGARITY
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore

Medical Hospital
Baltimore

W F
McNULTY
Baltimore

12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore

12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore
12-6-88 JJ
Baltimore

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09454

1. NAME OF DECEASED
(Type or Print)

ANTHONY

STRASDAUSKAS

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

21-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

907 Bayard Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 15, 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Insurance

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Valerian Strasdauskas

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph Strasdauskas 1700 Burrwood Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

907 Bayard Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 17 '66 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down stairs.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-21-1966

23C. NAME OF CEMETERY or CREMATORY

Most Holy Redeemer Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

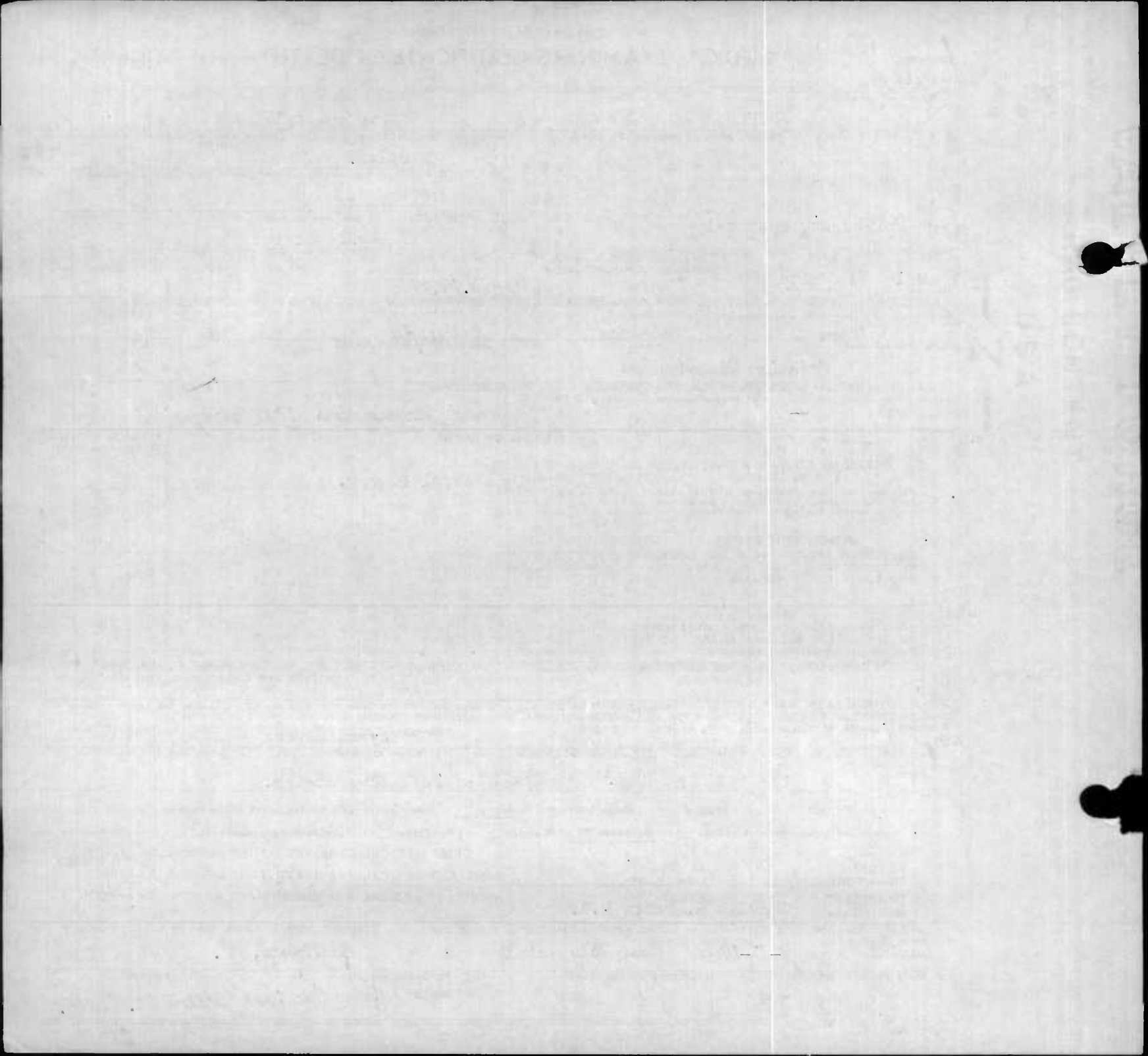
24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

R. E. Taylor, M.D.

Thomas J. Kenny Inc 1600 Hollins St. Balto.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 66 09455 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09455 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH 7:15 on 9/18/66 P.M. | | |
| 1. NAME OF DECEASED (Type or Print) <u>Norman Boyd</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-04</u> | | |
| 5. SEX <u>M.</u> 6. RACE <u>Ysgo.</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u> | | | D. STREET ADDRESS (If rural, give location) <u>21 S. Calverton Rd. 21223</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman - Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <u>64</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Hunter Boyd</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-019390</u> | |
| 17. INFORMANT <u>Alice Boyd</u> | | ADDRESS <u>Same</u> | | 18. 4 20, 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| CAUSE OF DEATH (A) <u>Myocardial infarction</u> (B) <u>Heart failure due to ASCVD</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (M) (this hospital) attended the deceased from <u>4:45 PM Sept-18 1966</u> to <u>7:15 PM Sept-18 1966</u> , that (W) (we) last saw the deceased alive on <u>7:15 PM Sept-18 1966</u> and that in (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (W) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <u>M. Chung</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED <u>9-18-66</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Y. CHUNG, M.D.</u> | | 23D. ADDRESS <u>Bon Secours Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/22/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Camer Mem. Park Laurel</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>Wilmington Phillips</u> | | ADDRESS <u>1727 N. Mount St.</u> | | | |

Important information
that follows

These are
the

M. C. C. C.
Y. C. C. C.

18-18-18
18-18-18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09456 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 66 09456 | |
|---|---------|--|-----------------------------------|--|-------------------------------|--|--------------------------------|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | Virginia F. Johnson | | September 18, 1966 1 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| 6 N. Rosedale Street Baltimore, Maryland 21229 | | | | Maryland | | 20-06 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 6 N. Rosedale Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| Female | Colored | Never Married | June 25, 1910 | 56 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | |
| House Wife | | | | | | Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | |
| USA | | | William Johnson | | | Mattie Hawkins | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| | | | | | | Mary Brown 6 N. Rosedale St. | | | |
| 18. 172X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | Respiratory Failure | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Adenocarcinoma of the | | | | | |
| | | | | Endometrium | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/19/66 8/27 19 to 9/18 1966 that (I) (we) last saw the deceased alive on 9/19/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| SPOROTSA | | | | 601 N. Monroe St Baltimore Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 9-21-66 | | Arbutus Mem. Pk. | | Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR | | | |
| SEP 20 1966 | | | Arlington S. Phillips | | | 1727 Monroe Street | | | |

Department of Defense
Office of the
Inspector General

8/18

8/18/00

8/18/00

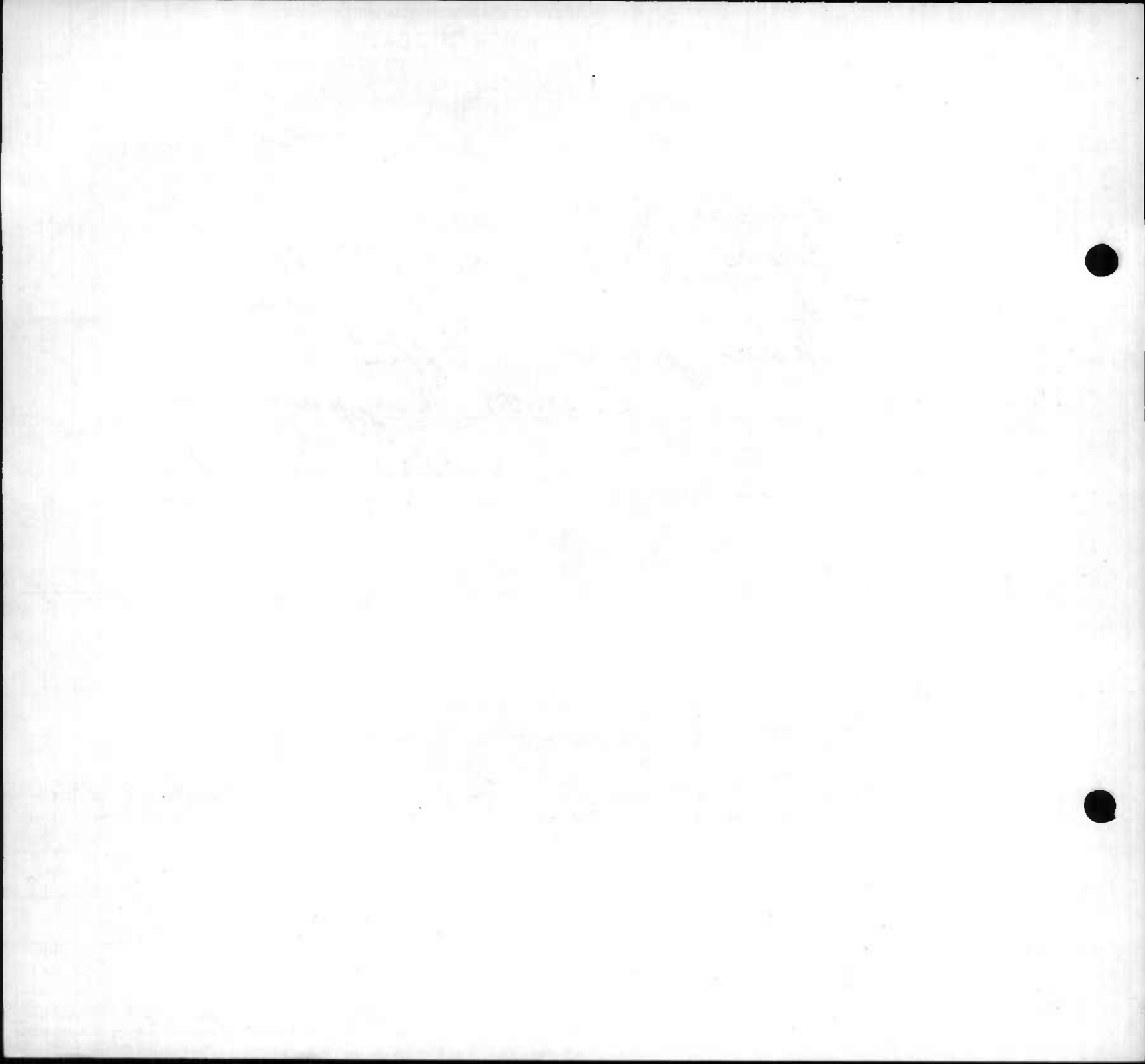
Col. M. M. M. M. M.

SECRET
J. M. M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09457 | |
|--|---------------------------|---|------------------------------------|--|---|
| BIRTH NO. 66 09457 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ernest Jones</i> | | 2. DATE AND HOUR OF DEATH <i>9/16/66 6:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE <i>Maryland</i> B. COUNTY <i>9-09</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>1406 Central ave. Baltimore, Md.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>1406 Central ave.</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>2/25/95</i> | 9. AGE (In years last birthday) <i>71</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>John Jones</i> | | 14. MOTHER'S MAIDEN NAME <i>Effie Henderson</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-03-9377</i> | | 17. INFORMANT <i>Mary Jones</i> ADDRESS <i>Same</i> | |
| 18. <i>442X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Cardio-renal Vascular Disease</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>?</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 10</i> 19 <i>66</i> to <i>Sept. 16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Sept. 15</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Wm. L. Berry</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Sept. 16 '66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Wm. L. BERRY</i> | | 23D. ADDRESS <i>1237 N. Caroline St.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/20/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>a.a. Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1966</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR <i>Wilmington S. Childs</i> | | ADDRESS <i>1921 N. Mount St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

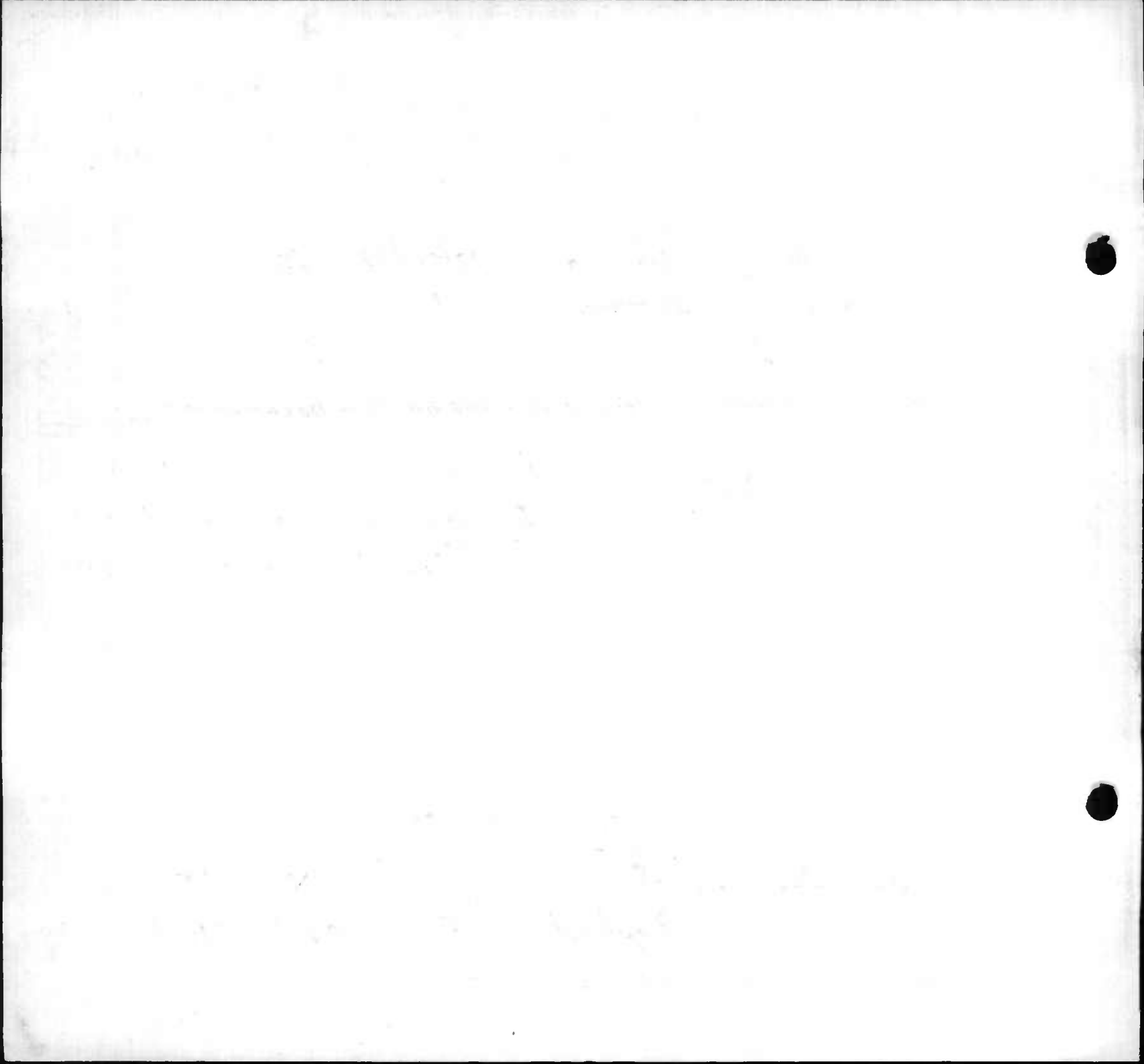
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 09458 | |
|--|------------------|---|---------------------------------------|---|----------------------------|--|-----------------------------|
| BIRTH NO. 66 09458 | | M.E. CASE NO. 2-8-92 | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Ida Godfrey</u> | | | | 2. DATE AND HOUR OF DEATH <u>10:40 a.m. 9/17/66</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hosp. of Baltimore</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>City Baltimore, MD.</u> D. STREET ADDRESS (If rural, give location) <u>429 Cummings Ct.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb 8 1902</u> | 9. AGE (In years last birthday) <u>44</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>States (MD)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Thomas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>daughter, Olivia Ayers</u> | | ADDRESS <u>Same</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>331X I</u> <u>Uremia</u> <u>CVA</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 15</u> 19 <u>66</u> to <u>Sept. 17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9:45 a.m. Sept. 17, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Won Ja Kim</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/17/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>WON JA KIM</u> | | | | 23D. ADDRESS <u>Lutheran Hosp. of Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/21/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mench. Baltimore</u> | | 24D. LOCATION (City, town, or county) (State) <u>MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Arlington Phillips</u> | | ADDRESS <u>1727 N. Mountz</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09459 | |
| BIRTH NO. 66 09459 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH Sept. 17th 1966 2:05 A.M. | |
| 1. NAME OF DECEASED (Type or Print) John Herring | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore 13-08 | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | D. STREET ADDRESS (If rural, give location) 1305 Union Ave. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED. | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | 8. DATE OF BIRTH 10/21/99 | 9. AGE (In years last birthday) 66 |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 144-01-2068-A | |
| 17. INFORMANT ROSE J. HERRING | | ADDRESS 1305 UNION AVE. | |
| 18. 327.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspiration Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory Acidosis and Electrolyte disturbance | | UnKnown | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Obstructive Emphysema | | UnKnown | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 8th 1966 to Sept 17th 1966 , that (I) (we) last saw the deceased alive on Sept 17th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE William Cieplinski | | 23B. DATE SIGNED 9/17 66 | |
| 23C. PHYSICIAN'S NAME (Type) William Cieplinski | | 23D. ADDRESS Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/66 | |
| 24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH | | 24D. LOCATION (City, town, or county) (State) BALTO, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Robert E. Taylor | | ADDRESS 3601 Chestnut Ave. | |



BIRTH NO.

66 09460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 09460

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

David L. Worrell

2. DATE AND HOUR PRONOUNCED DEAD

9/16/66

8:15 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

802 Power St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED.

8. DATE OF BIRTH

12/22/04

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-03-9373

17. INFORMANT

ADDRESS

MARY WORRELL 802 POWER ST.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/19/66

23C. NAME OF CEMETERY or CREMATORY

LORRAINE PARK

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1966

24B. NAME OF REGISTRAR

Paul E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul E. Charney, M.D.

ADDRESS

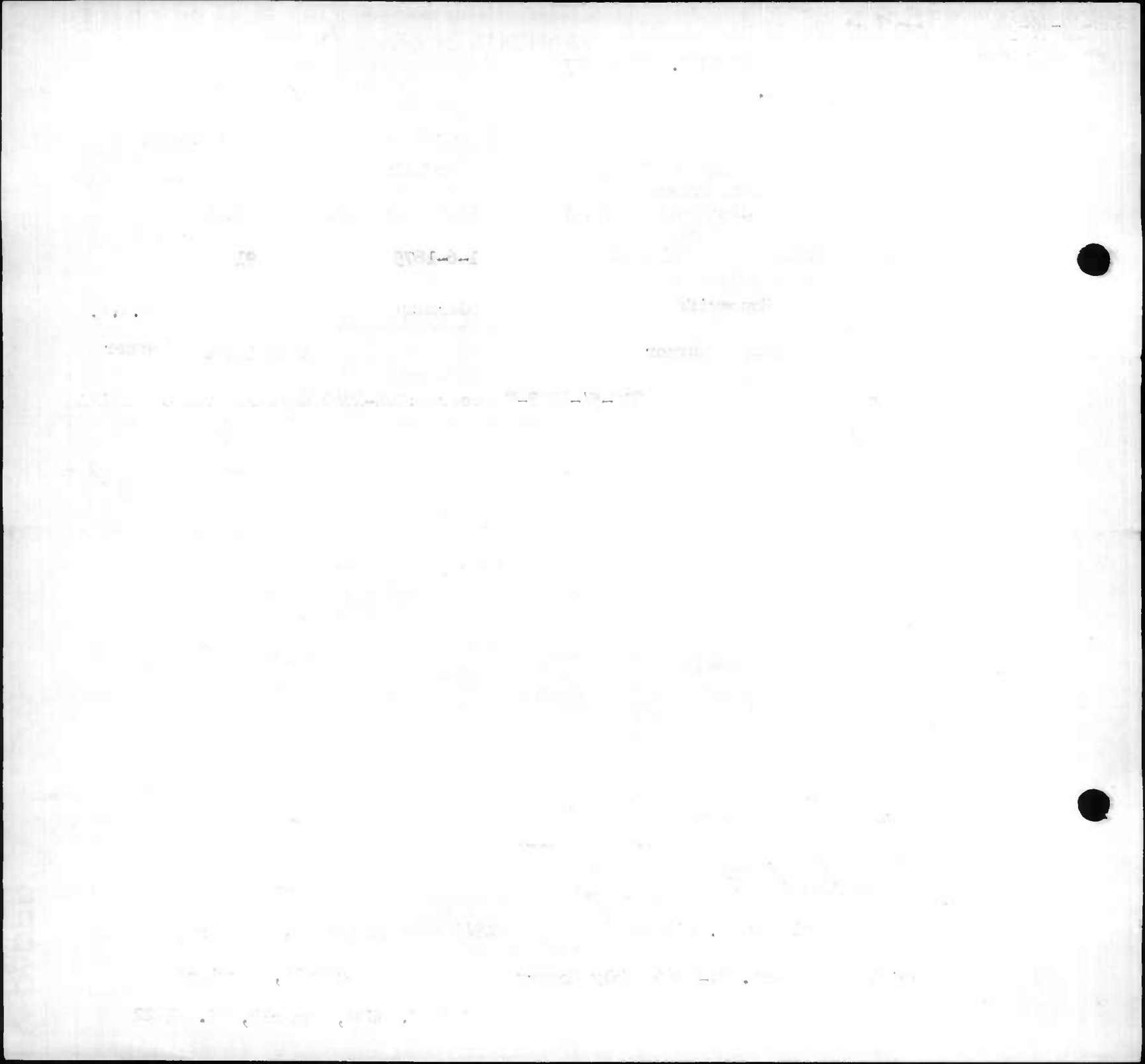
VALLEY COLLEGE

MAJOR JEFFREY

1905

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

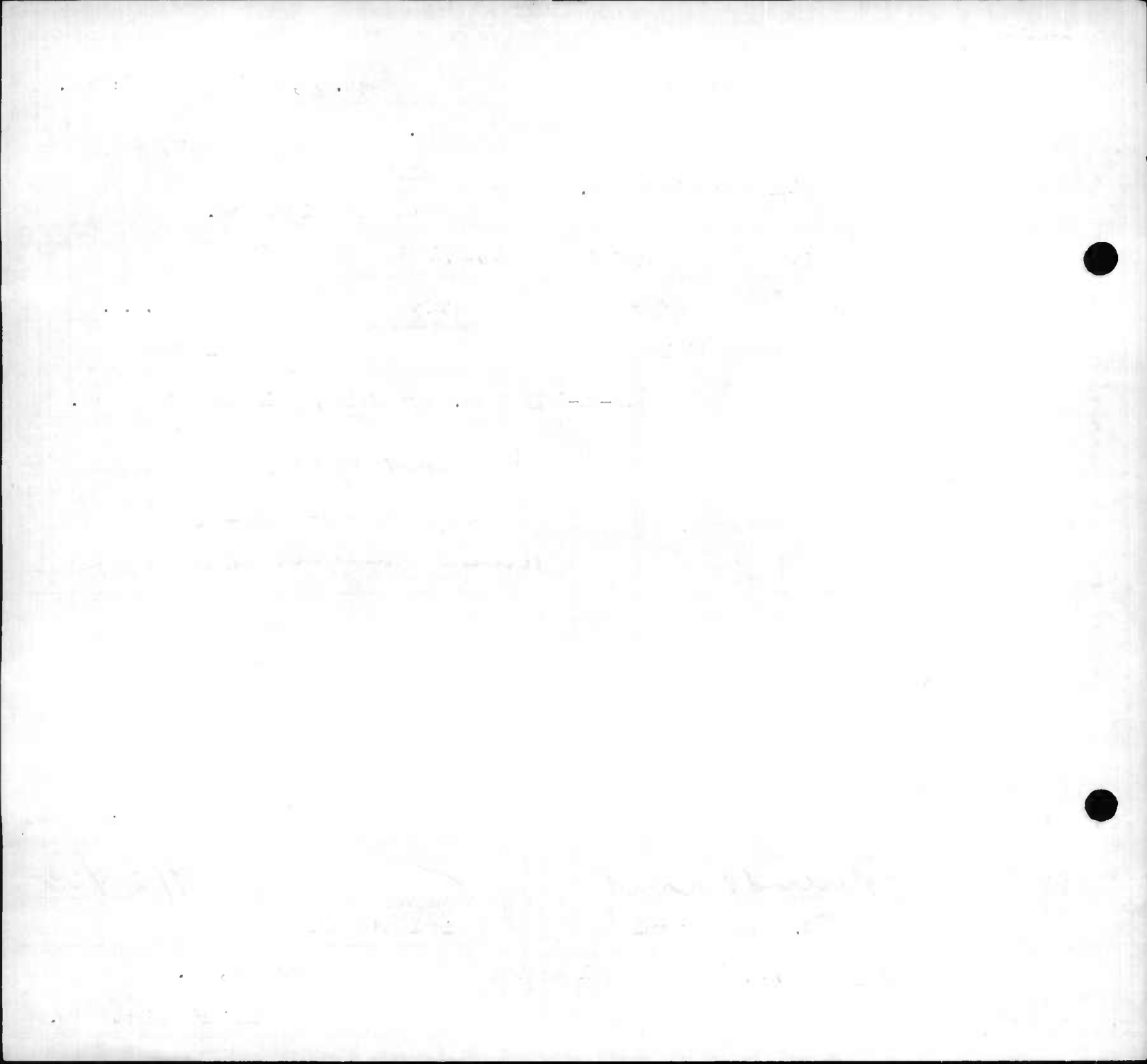
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09461 | |
|--|---------------|--|---------------------------|---|--|
| BIRTH NO. 66 09461 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. AGNES S. ZOLTOWSKI | | 2. DATE AND HOUR OF DEATH 9-18-66 11:35 A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) Agnes S. Zoltowski | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location) 1627 Lynch Road 21222 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-6-1875 | 9. AGE (In years last birthday) 91 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Adam Wagner | | 14. MOTHER'S MAIDEN NAME Antoniette Wagner | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 217-54-1373-T | | 17. INFORMANT ADDRESS Records: BCM-4940 Eastern Avenue 21224 | | | |
| 18. 199-2-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Undifferentiated leukemia DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) metastatic to liver + DUE TO | | | |
| | | (C) Spinal column | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 9-17 1966 to 9-18 1966, that (We) last saw the deceased alive on 9-18 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard L. Bishop M.D. | | | | 23B. DATE SIGNED 9-18-66 | |
| 23C. PHYSICIAN'S NAME (Type) Richard L. Bishop | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 21-1966 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | |
| 24D. LOCATION (City, town, or county) Dundalk, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jarley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Dundalk, Md. 21222 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|--|---|---|
| BIRTH NO. 66 09462 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09462 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Frank LiPira | | | 2. DATE AND HOUR OF DEATH Sept. 19, 1966 6:00 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4641 Park Heights Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-16 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4641 Park Heights Ave. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/17/1898 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10B. KIND OF BUSINESS OR INDUSTRY Barber Shop | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Joseph LiPira | | | 14. MOTHER'S MAIDEN NAME Glorioso | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-01-6443 | 17. INFORMANT ADDRESS Mrs. Mary LiPira, 4641 Park Heights Ave. | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Arteriosclerosis DUE TO (C) Uremia - renal arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year 1 year |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 1964 to Sept 18 1966 , that (I) (we) last saw the deceased alive on 9/11 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard Fravel M.D. | | | | 23B. DATE SIGNED 9/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) C. Richard Fravel | | | 23D. ADDRESS M.D. Medical Arts Building | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS Lo Vernon Gannon 4611 Park Heights Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 66 09463 | |
|---|------------------|--|--------------------------------------|---|--|--|------------------------------|
| BIRTH NO. 66 09463 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Allen T Douglas</u> | | 2. DATE AND HOUR OF DEATH <u>Sept 14 1966 9:30</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <u>MD</u> | | B. COUNTY <u>BALTO</u> | | 27-05 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | D. STREET ADDRESS (If rural, give location) <u>3123 Clearview Ave</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>Sept 30 1894</u> | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIN TANCE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u> | | 11. BIRTHPLACE (State or foreign country) <u>VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Douglas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lena</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>225-16-2810</u> | | 17. INFORMANT <u>Bertie Douglas</u> | | ADDRESS <u>Same</u> | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>Arteriosclerosis</u> DUE TO <u>B.V. Disease</u> (B) <u>Parkinson's Disease</u> DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Apr 15 1946</u> to <u>9/14 1966</u> that (I) (we) last saw the deceased alive on <u>9/14 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Nathan Jarney</u> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/16/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>NATHAN JARNEY</u> | | | | 23D. ADDRESS M.D. <u>7101 Harford Rd.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>Sept 17-1966</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u> | | 24D. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jarney</u> | | 25C. FUNERAL DIRECTOR <u>Chas F. Evans & Son</u> | | ADDRESS <u>8802 Harford Rd</u> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09464 | |
|--|-------------------------|---|-------------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mary B. Jokubaitis | | 2. DATE AND HOUR OF DEATH 9-19-66 8⁴⁵/A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 EASTERN AVENUE - 21224 826 Hollins St. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-15-83 | 9. AGE (In years lost birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Tailoring Co. | | 11. BIRTHPLACE (State or foreign country) Lithuania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME NOT KNOWN | | 14. MOTHER'S MAIDEN NAME NOT KNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-12-0541 | | 17. INFORMANT RECORDS: BCM 4940 Eastern Ave. Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 332X+1-260X Recurrent Cerebral Vasc. Thromboses | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 19 mo. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus | | | | 10+ yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-7-1965 to 9-19-1966 , that (I) (we) last saw the deceased alive on 9-18-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Wm. A. Emerson | | | | 23B. DATE SIGNED 9-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM A. EMERSON | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/66 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Parky | |
| 25C. FUNERAL DIRECTOR John J. Cowanston Inc | | 25D. ADDRESS 826 Hollins St. 23. Md. | | | |

Copy to [illegible]

2-12-66

22

18-2-82

Mount General West. Thomas

Richard Miller

20/10

22-11-66

4-12-66

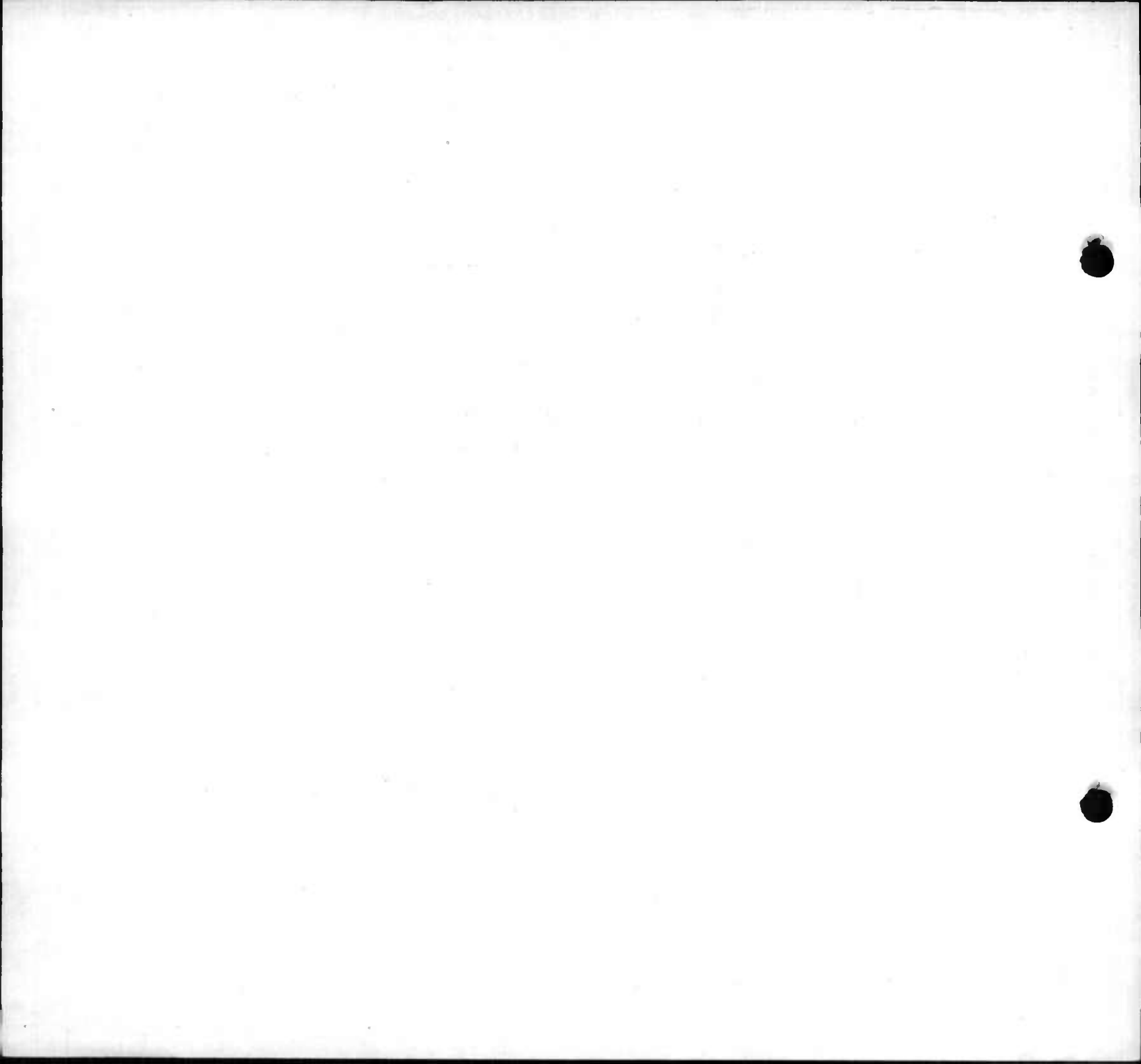
Wm. D. [illegible]

2-12-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09465 | |
| CERTIFICATE OF DEATH | | | |
| BIRTH NO. 33966 09465 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) ELDRIDGE SCOTT | | 2. DATE AND HOUR OF DEATH 9/16/66 12⁴⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinia Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 15-13 | |
| 5. SEX M | | 6. RACE NEGRO | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 1-4-24 | |
| 9. AGE (In years last birthday) 42 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Andrew Coates | | 14. MOTHER'S MAIDEN NAME Hilda Scott | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-12-3838 | |
| 17. INFORMANT Margaret Scott | | ADDRESS 3535 Virginia Ave. | |
| 18. 3-92 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HTF FAILURE (A) DUE TO CHRONIC RENAL DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC Renal Disease (B) DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 7 AM 9/16 19 66 to 12⁴⁵ PM 9/16 19 66 , that (1) (we) last saw the deceased alive on 9/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE James S. Soley | | 23B. DATE SIGNED 9/16/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-20-66 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR George G. Kelson | | ADDRESS 1348 N. Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|--|--|---|---|
| BIRTH NO. 6600 09466 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09466 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Laury | | 2. DATE AND HOUR OF DEATH 9-18-66 11:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Inc. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1728 Warwick Ave. | | 15-03 | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/25/06 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME HENRY LAURY | | 14. MOTHER'S MAIDEN NAME ROSETHA HUNT | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 24-12-2971 | 17. INFORMANT MARY LAURY | | ADDRESS 1728 WARWICK AVE |
| 18. 770.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease injury or complication which caused death.) Intracranial Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Overdose of Coumadin | | CAUSE OF DEATH Intracranial Hemorrhage Overdose of Coumadin | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular Disease | | | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1728 Warwick Avenue | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Approx. 9/11/66 | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? Apparently inadvertent, self administered overdose of coumadin. | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/11 19 66 to 9/18 19 66 , that (2) (we) last saw the deceased alive on 9/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allan S. Rudolph | | M.D. | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED 9-18-66 | |
| 23C. PHYSICIAN'S NAME (Type) Allan S. Rudolph | | M.D. | 23D. ADDRESS Sinai Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9-22-66 | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk. | | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robt E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS GEORGE KELSON 1348 Calhoun St. | |

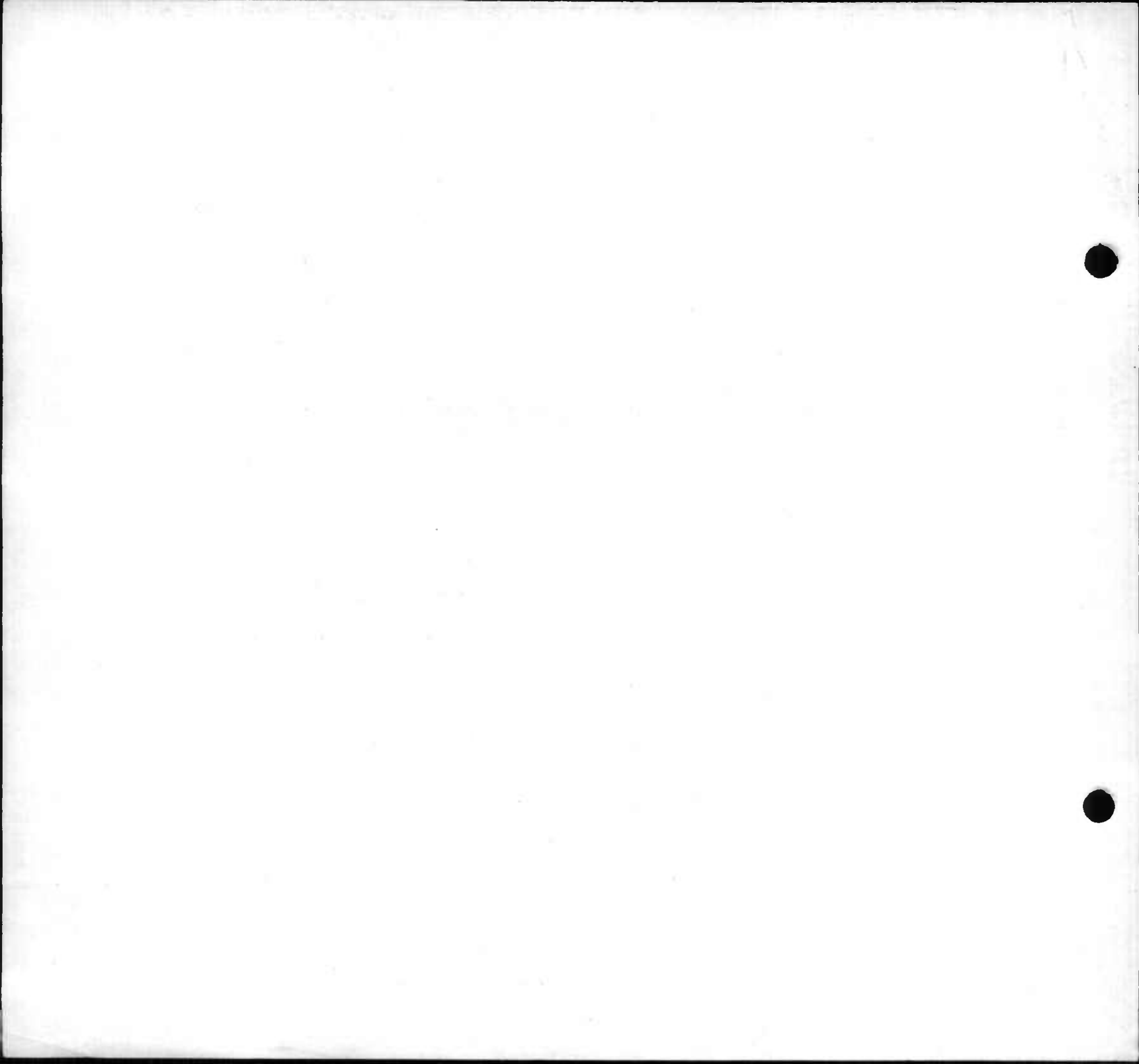
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June 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. T 520 66 09467 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09467 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) THOMAS, LUKE | | | 2. DATE AND HOUR OF DEATH SEPT. 19, 1966 12:05 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND JINAI HOSPITAL OF BALTIMORE <small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3655 PARK HEIGHTS AVE #15 | | |
| 5. SEX MALE | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH MAY 10, 1894 | 9. AGE (In years lost birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEVEDORE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) S. CAROLINA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME WASHINGTON THOMAS | | | 14. MOTHER'S MAIDEN NAME HESTER PETTIGREW | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES UNKNOWN | | 16. SOCIAL SECURITY NO. 212-09-6159 | 17. INFORMANT ADDRESS HESTER ALSTON 3655 PARK HEIGHTS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO R/o pulmonary infarct. (B) DUE TO myocardial infarct. (C) general debility metastatic carcinoma to the lung. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | possible adenocarcinoma (1° GIT) | | |
| 19A. DATE OF OPERATION 19-12-66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pleural effusion | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 19 19 66 to Sept. 19 19 66 . that (I) (we) last saw the deceased alive on Sept. 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Reynaldo P. Madriano M.D. | | | | 23B. DATE SIGNED Sept. 19, 1966 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-23-66 | 24C. NAME OF CEMETERY or CREMATORY Balt. Nat'l. Cemetery | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Paul E. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS George Kelson 1348 N. Calhoun St. | |

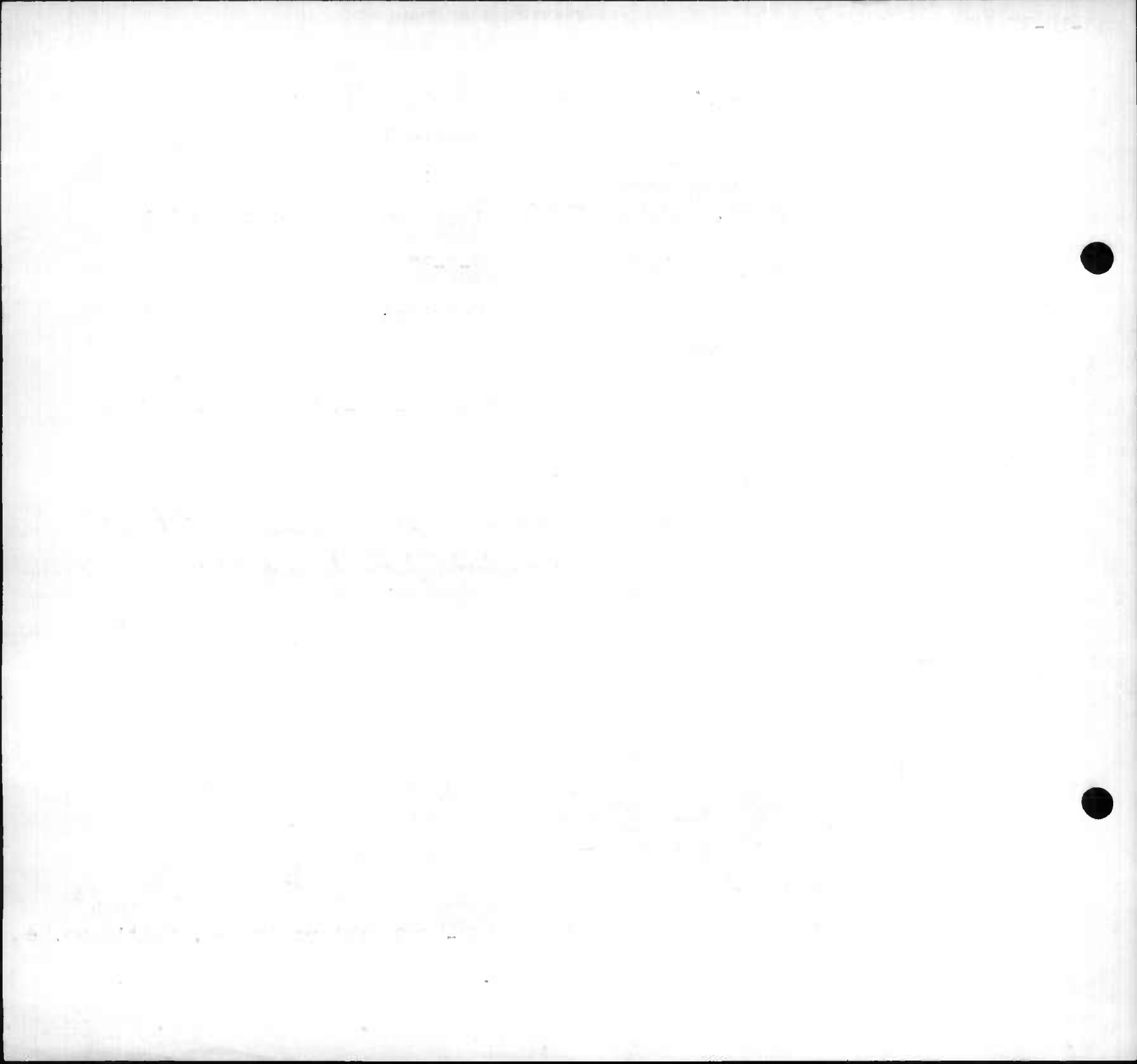


35-10-37 1B


FUNERAL DIRECTOR: IMPORTANT

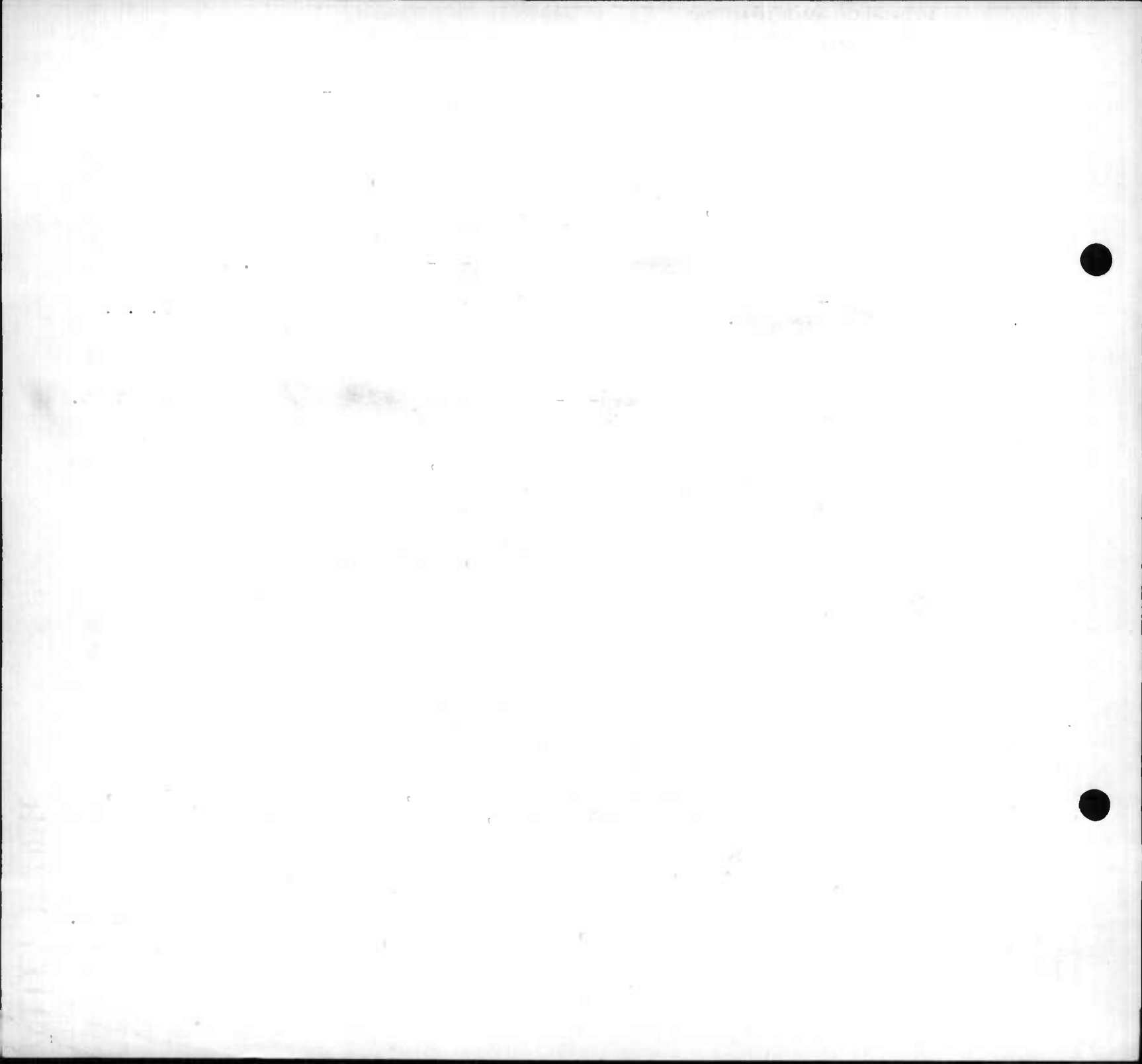
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09468 | |
|--|--|---|--|---|--|
| BIRTH NO. 520 66 09468 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>Calvin S. Jones</u> | | | 9/17/66 11:00 p. m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>16-02</u> | | |
| 5. SEX <u>Male</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | |
| 6. RACE <u>Negro</u> | | | D. STREET ADDRESS (If rural, give location) <u>1425 Laurens Street</u> <u>#21217</u> | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | | | 8. DATE OF BIRTH <u>8-7-30</u> | | |
| 9. AGE (In years last birthday) <u>36</u> | | | 10. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Columbus</u> | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>RECORDS-BCH-4940</u> | | | ADDRESS <u>#21224</u> <u>EASTERN AVENUE</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory collapse</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Drum negative sepsis</u> | | | <u>3-4 days</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>multiple decubiti, infected GU infections</u> | | | <u>several months</u> | | |
| 19A. DATE OF OPERATION <u>Aug 66</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>renal shutdown, quadriplegia 2 leg ulcers 4 yrs</u> | | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> 19 <u>66</u> to <u>9/17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Terry Ersel Gagon</u> | | | 23B. DATE SIGNED <u>9/17/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Terry Ersel Gagon</u> | | | 23D. ADDRESS <u>BCH-4940 Eastern Avenue, Baltimore, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-21-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Jones Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Anne Arundel, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | | |
| 25B. NAME OF REGISTRAR <u>Lab E. Fairley</u> | | 25C. FUNERAL DIRECTOR <u>George G. Kelson</u> | | | |
| 25D. ADDRESS <u>1348 N. Calhoun St.</u> | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

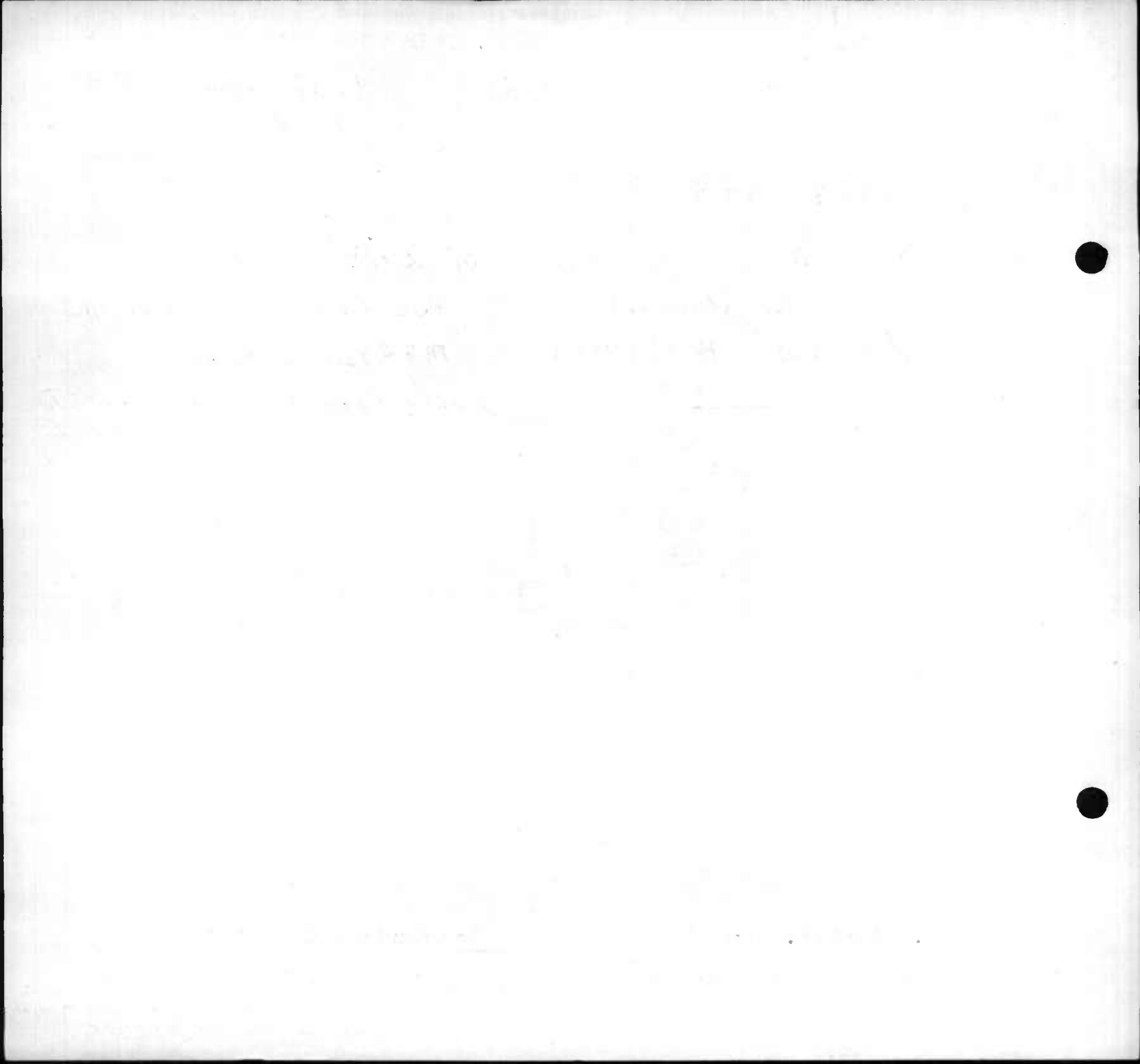
| | | | | | |
|---|------------------|--|-------------------------------|---|---|
| BIRTH NO. 66 09469 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09469 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Tyler Lee | | 2. DATE AND HOUR OF DEATH 9-19-66 5:00 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | D. STREET ADDRESS (If rural, give location) 1125 Whatcoat Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 2-25-1898 | 9. AGE (In years last birthday) 68 yrs. | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 096-16-4530 | | 17. INFORMANT Hilda Gale 1125 Whatcoat St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, Possible Hemolytic Jaundice Uremia, Renal Failure | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 20 Days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 30, 1966 to September 19, 1966, that (I) (we) last saw the deceased alive on September 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-20-66 | |
| 23C. PHYSICIAN'S NAME (Type) Ramachrandran, | | M.D. 23D. ADDRESS Provident Hospital 1514 Division St. Baltimore, Maryland 21217 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-23-66 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. (City, town, or county) | | 24F. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR George Kelson 1348 N. Calhoun Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09470 | |
|--|--------------|---|-------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66 09470 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mr. Hipolit RASINSKI | | 2. DATE AND HOUR OF DEATH 9. 17. 1966 5:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEM. HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 1366 Andre ST | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 08/2/1886 | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired (Longshoreman) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? POLAND | | 13. FATHER'S NAME John RASINSKI | | 14. MOTHER'S MAIDEN NAME MARYANNA Loch | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Sophie Rasinski 1366 Andre ST | |
| 18. 58701 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Peritonitis (B) DUE TO Acute pancreatitis (C) DUE TO | | Interval between onset and death Short | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Chronic emphysema ASCVD | | | |
| 19A. DATE OF OPERATION 3 08/22/1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE jaundice | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? pancreas YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 08. 12. 1966 to 09. 17. 1966, that (we) last saw the deceased alive on 09. 17. 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death. | | | |
| 23A. SIGNATURE Giselle Bretz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9. 17. 1966 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Giselle T. Bretz | | 23D. ADDRESS The Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/66 | | 24C. NAME OF CEMETERY or CREMATION Holy Rosary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR ADDRESS Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue | | | | | |



40-51-76

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

66 09471

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 09471

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Mary G. Lewis

2. DATE AND HOUR OF DEATH

September 19, 1966

1:00

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1151 N. Bentalou Street 21216

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

4-6-1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William

Roots

14. MOTHER'S MAIDEN NAME

Mary Nelson

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 493X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pneumonia

1 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Mul. Myeloma

4 yrs.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (D) (this hospital) attended the deceased from 9/19 19 66 to 9/19 19 66,
that (D) (we) last saw the deceased alive on 9/19 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Richmond

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/19/66

23C. PHYSICIAN'S
NAME (Type)

Dr. Joel Richmond

23D. ADDRESS

M.D. Baltimore City Hospitals 4940 Eastern Avenue

21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 9/22/66

Arbutus Mem Pk

Arbutus

Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1966

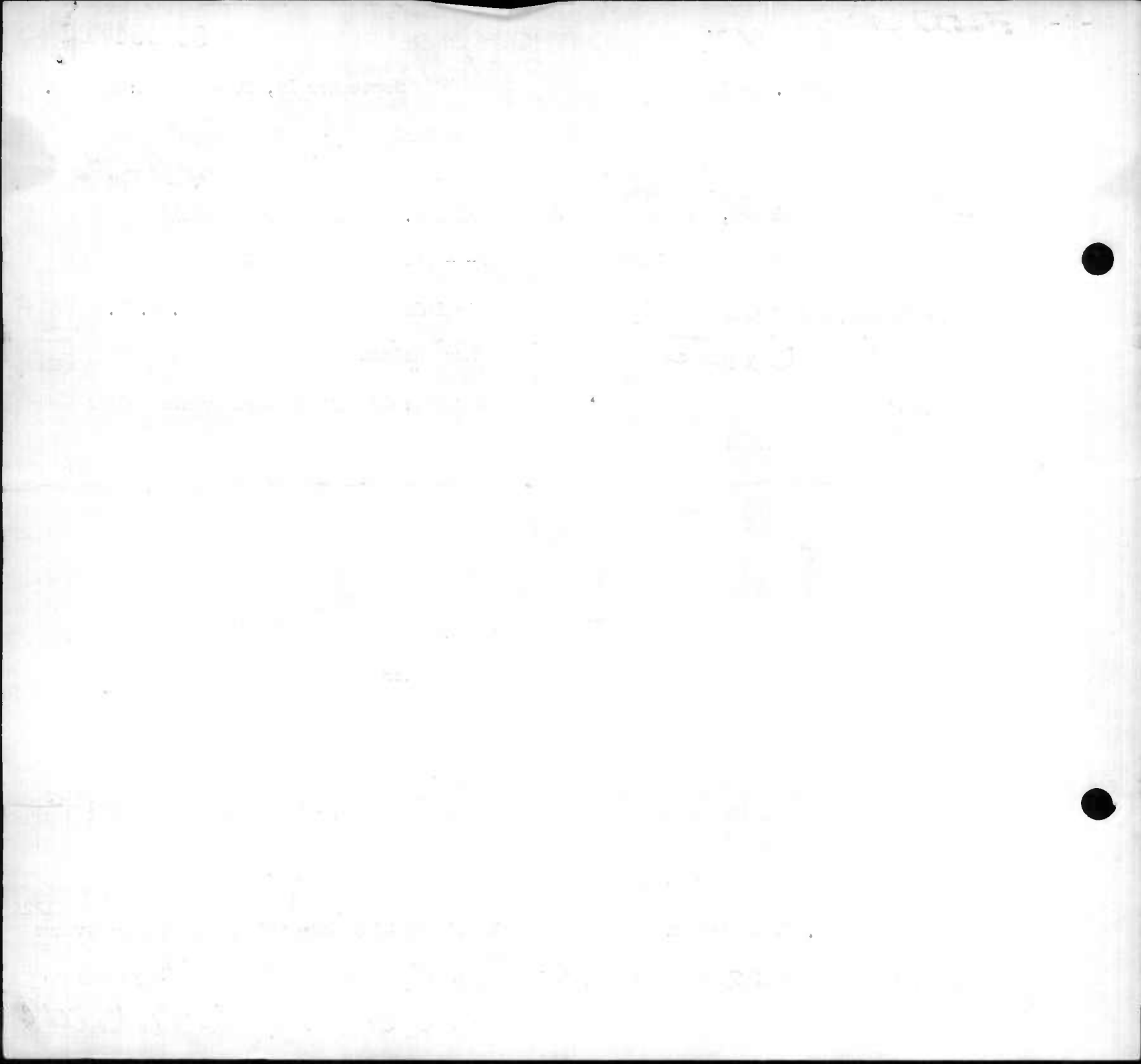
25B. NAME OF REGISTRAR

Earl E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Earl E. Taylor 1827 W. North E

ADDRESS



1
C-640

66 09472

BALTIMORE CITY HEALTH DEPARTMENT

66 09472

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|--|-------------------------|--|--|--|---|
| 1. NAME OF DECEASED (Type or Print) SARAH MILDRED GROHOL | | | 2. DATE AND HOUR PRONOUNCED DEAD September 17, 1966 12:46 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 99 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 52-00 D. STREET ADDRESS (If rural, give location) 5225 Wasena Avenue | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Jan. 5, 1923 | 9. AGE (In years last birthday) 43 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Alpheus Dixon | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joseph E. Grohol, 5225 Wasena Ave., |

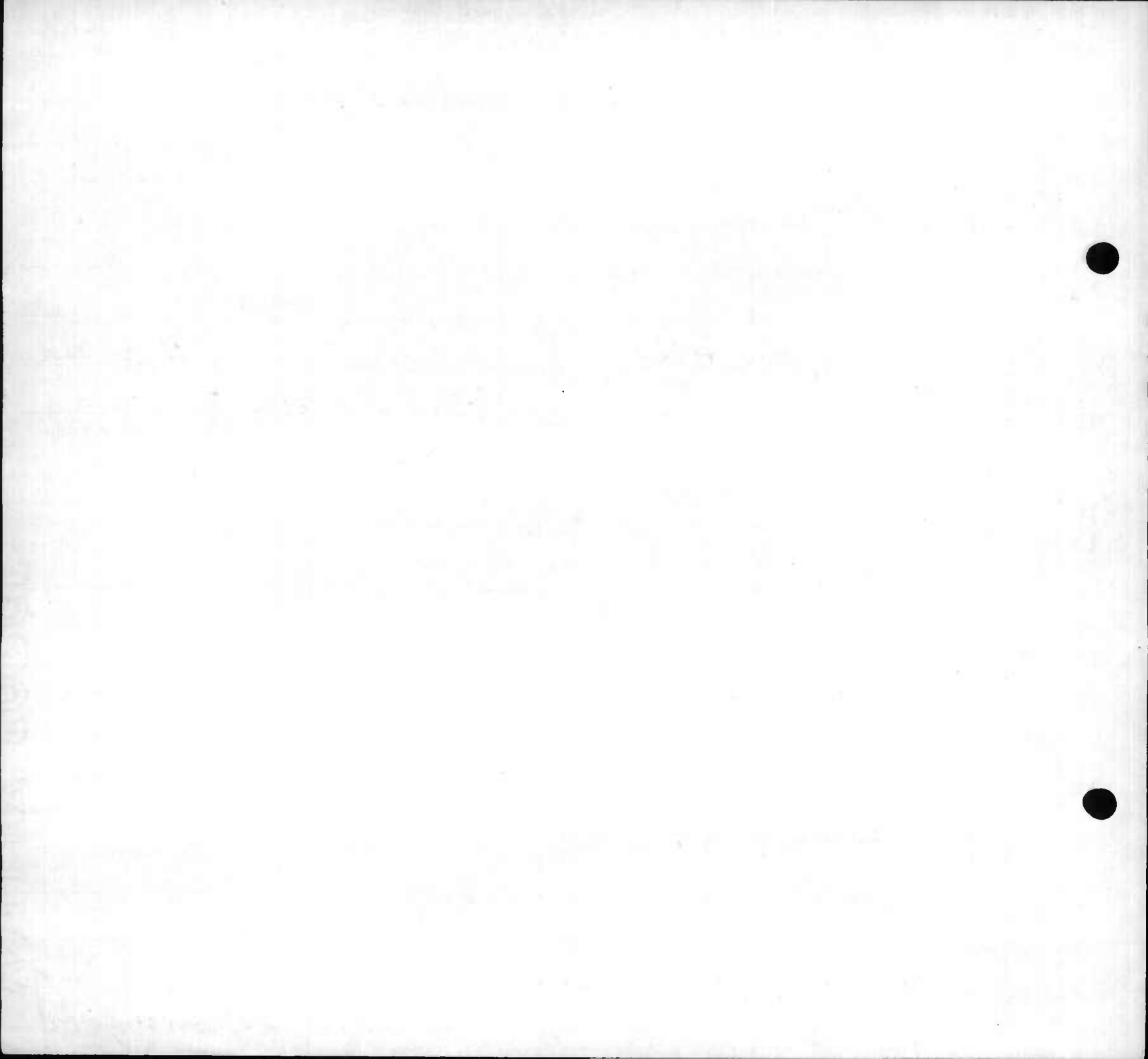
| | | | | | | |
|-----------------------|---|--|--|--|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Heart Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| | 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | 21F. HOW DID INJURY OCCUR? | | | | | |
| | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| | ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED 9/17/66 |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Sept. 21, 1966 | 23C. NAME OF CEMETERY or CREMATORY Sudlersville Cemetery | | 23D. LOCATION (City, town, or county) (State) Sudlersville, Maryland |
| | 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 24B. NAME OF REGISTRAR Robert E. Farber | | 24C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hgwy.-Baltimore | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

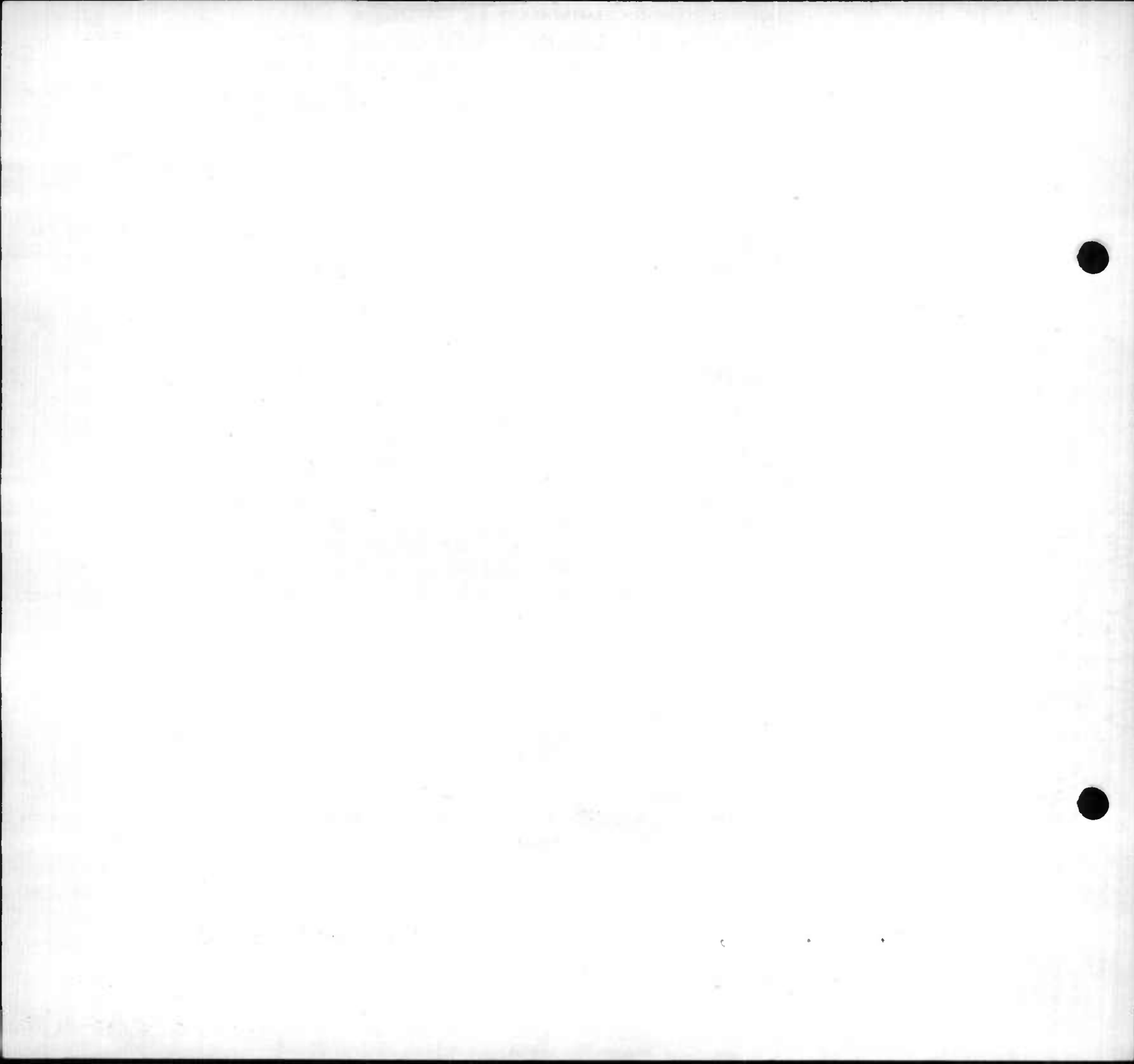
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|------------------------|--|---|--|---|--|---|---|---------|--|
| 66 09473 | | | | | 66 09473 | | | | | |
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | Registered No. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>John Thomas Hall</i> | | | | | 2. DATE AND HOUR OF DEATH <i>9/16/66</i> <i>1:00 AM</i> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Hyde</i> <i>53-00</i> | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>CAUC</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid</i> | 8. DATE OF BIRTH <i>4-15-76</i> | 9. AGE (In years last birthday) <i>90</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver - former</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Hall, John Hall</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Sally Johnson, Hyde Md.</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. <i>215-10-1094</i> | | 17. INFORMANT <i>J. Vernon Hall, Fair, Md.</i> | | | | | |
| 18. <i>650,01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>Pulmonary Emboli</i> DUE TO (B) <i>Acute Appendicitis</i> DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> <i>10 days</i> <i>10 days</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Acute urinary retention</i> | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>9/17/66</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Appendicitis</i> | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/6</i> 19 <i>66</i> to <i>9/16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/15/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Leighton Siegel</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>9/16/66</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Leighton Siegel</i> | | | | | 23D. ADDRESS M.D. <i>Maryland General Hospital</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>9/18/66</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Fair Christian</i> | | 24D. LOCATION (City, town, or county) (State) <i>Fair Md</i> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 20 1966</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Faldut</i> | | | 25C. FUNERAL DIRECTOR <i>W. H. Archer, Benson, Md</i> | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

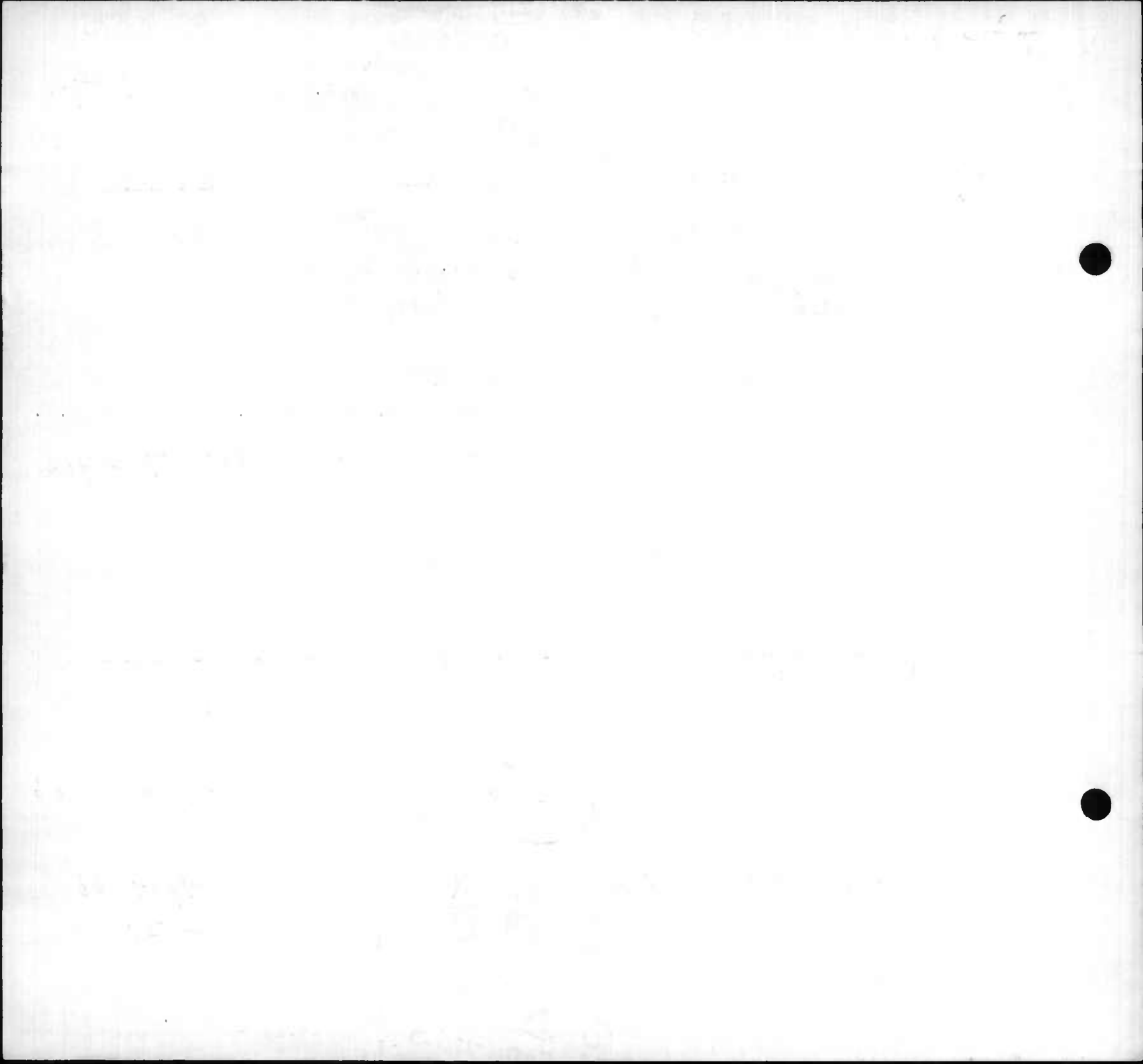
| | | | | | |
|---|--------------|---|-------------------------------|--|--|
| BIRTH NO. 66 09474 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09474 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Clara Margaret Kohlman | | 2. DATE AND HOUR OF DEATH Sept 17, 1966 6:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-02 | | | |
| | | D. STREET ADDRESS (If rural, give location) 4218 Stanwood Ave. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/19/1913 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Homemaking | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME David F. Baynes | | 14. MOTHER'S MAIDEN NAME Mamie O'Brien | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Walter Kohlman | |
| 18. 296X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Meningo gastro intestinal hemorrhage (B) DUE TO Thrombocytopenia (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/5/66 to 9/17/66 that (1) (last saw the deceased alive on 9/17/66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (did) (view the body after death. | | | | | |
| 23A. SIGNATURE Nat E. Watson Jr. | | | | 23B. DATE SIGNED 9/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Nat E. Watson, Jr. | | | | 23D. ADDRESS The Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | |
| 24D. LOCATION BALTIMORE MD | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR G. S. E. Taylor | |
| 25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME | | 25D. ADDRESS 41210 BELAIR RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09475 | |
|---|---------|--|--------------------------|---|--|
| 66 09475 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | ELIZABETH JEAN FAUGHT | | Sept. 16, 1966 9 35 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | |
| 201 Athol Gate Lane | | | | Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Baltimore 28-04 | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 201 Athol Gate Lane | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: Hours: Min. |
| F | W | Widow | Nov. 2, 1883 | 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Richmond Virginia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Thomas Mackie | | | Mary Trower | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | Mr Ray C. Faught Jr. Schnectady N.Y. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 7 1/2 yrs | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/25/1943 to 9/16/1966, that (I) (we) last saw the deceased alive on 9/15/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Robert A. Pette | | | | 9/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Robert Reiter | | 606 Edmondson Avenue - 28 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/20/66 | | Woodlawn Cemetery | |
| | | | | Woodlawn Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 20 1966 | | Robert E. Farley | | HENRY SANDER & SONS INC. BALTIMORE MARYLAND | |



66 09476

BALTIMORE CITY HEALTH DEPARTMENT

66 09476

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELMER A. LARSON (JOKINEN, ILMARI)

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966 8:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1837 E. Lombard Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1837 E. Lombard Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 14, 1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Butler & Counterman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Abe Finland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

August Jokinen

14. MOTHER'S MAIDEN NAME

Eva Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes World War # 2 118 14 3873

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Wilma A. Larson 1837 E. Lombard

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Pancreas.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county) (State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1966

Robert E. Farley

HENRY SANDER & SONS INC.

BALTIMORE, MARYLAND 21213

WALLEY FORTGE

KAR FORTGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--|--|---|
| BIRTH NO. 66 09477 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09477 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Solomon Hawkins | | | 9-18-66 7:45 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217 | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 14-03 | | |
| D. STREET ADDRESS (If rural, give location) 1902 McCulloh Street | | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 5-8-05 | 9. AGE (In years last birthday) 61 yrs. | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed PACKER - MOVING Co. | | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 231-07-0167 | 17. INFORMANT ADDRESS Mrs. Riggins (Daughter) Norfolk, Va. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro Vascular Insufficiency | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 17, 1966 to September 18, 1966, that (I) (we) last saw the deceased alive on September 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-20-66 |
| 23C. PHYSICIAN'S NAME (Type) Dr. C. Laredo | | | 23D. ADDRESS Provident Hosp. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 9/19/66 | | 24C. NAME OF CEMETERY OR CREMATORY ROOSEVELT MEM. PR CHESAPEAKE VA | |
| 24D. LOCATION (City, town, or county) (State) CHESAPEAKE VA | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR [Signature] | |
| 25C. FUNERAL DIRECTOR [Signature] | | 25D. ADDRESS [Signature] | | 25E. ADDRESS [Signature] | |

Parker - 1910

W. H. Parker

W. H. Parker

10

W. H. Parker

W. H. Parker

W. H. Parker

W. H. Parker

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|------------------|--|------------------------------|
| 66 09478 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09478 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| QUICK, M ^{rs} Winslow. | | 9/17/66 | | 4 20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Church Home & Hospital of Baltimore City | | Maryland Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Dundalk. | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 74 Yorkway | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| M | W | married | 3/25/1898 | 68 | USA. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Steel Worker. LAYOUT MAN | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| HARRY Quick. (Unknown) | | (Unknown) Mules. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 213-07-0136 | | Margaret Winslow 74 Yorkway. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Arteriosclerotic Cardio Vascular | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Disease | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 9 years. | |
| Pulmonary Emphysema. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/17 19 66 to 9/17 19 66, that (we) last saw the deceased alive on 9/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| for Mary | | 9/17/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Vase MARTINEZ | | 100 N. Broadway. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 9/20/66 | | PARKWOOD CEMETERY | |
| | | | | PARKVILLE MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | Robert E. Johnson | | ULLRICH FUNERAL HOME DUNDALK MD | |

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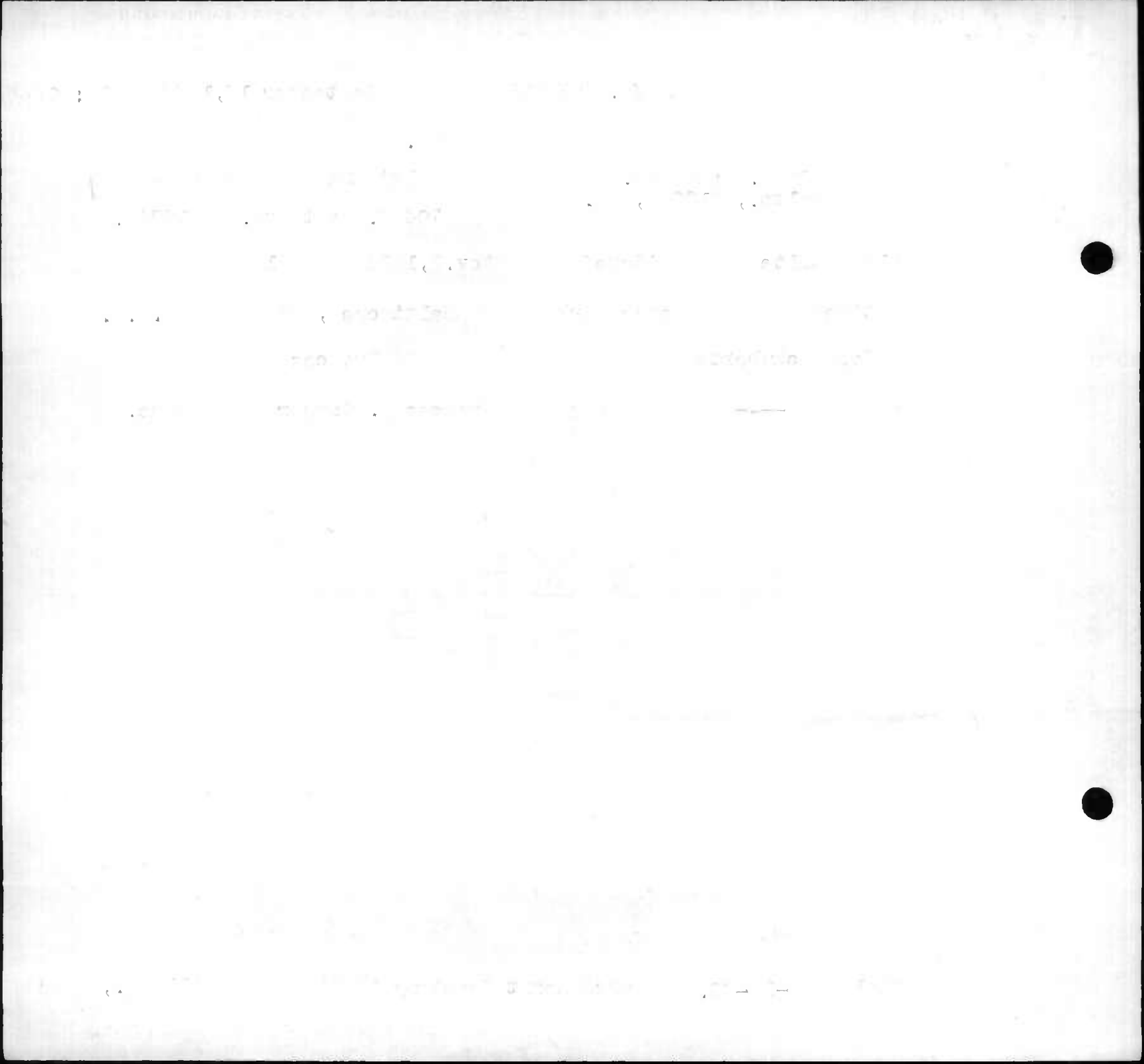
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09479</u> | |
|--|----------------------|---|--------------------------------------|--|---|
| BIRTH NO. <u>66 09479</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>MAGDALENA J. TRIBULL</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>September 16, 1966 10:30 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>704 S. East Ave. Balto., 21224, Md.</u> | | A. STATE <u>Md.</u> B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>704 S. East Ave. # 21224</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Nov. 9, 1884</u> | 9. AGE (In years last birthday) <u>81</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>House Work</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>John Schubert</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT ADDRESS <u>Frances M. Copper Same.</u> | |
| 18. <u>157X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Pancreas</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Carcinoma of Liver and Biliary Tract</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 14, 1966</u> to <u>September 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 15, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Andrew Kuzkowski</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/18/66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Andrew Kuzkowski</u> | | 23D. ADDRESS <u>2529 Eastern Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-19-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd. Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Charles S. Giller</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>901 S. CONKLING ST. BALTO., 21224, MD.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09480 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09480 | |
|---|-------------------------|---|---|--|--|---|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Andrew Cerny</u> | | | | 9-15-66 4:15 4:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVE.</u> <u>BALTO., MD. 21224</u> | | | | A. STATE <u>MARYLAND</u> B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>4719 EASTERN AVE. 21224</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>11/21/02</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>THOMAS CERNY</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>JULIA KLEMPA</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>215-18-7754</u> | | | 17. INFORMANT ADDRESS <u>RECORDS-BCM 4940 EASTERN AVE. BALTO., MD. 21224</u> | | | | |
| 18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Insufficiency</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hemoptysis + Aspiration</u> <u>Squamous cell Ca Lung</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>4 days</u> <u>3 months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>June 21</u> 19 <u>66</u> to <u>Sept 15</u> 19 <u>66</u> , that <u>(A)</u> (we) last saw the deceased alive on <u>Sept 15</u> 19 <u>66</u> and that in <u>(A)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(A)</u> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Richard L. Bishop</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9-15-66</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Richard L. Bishop</u> | | | | 23D. ADDRESS <u>Baltimore City Hospitals 4940 Eastern Ave. Balto., Md. 21224</u> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-19-66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>6515 Boston Ave. Balto., MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Charles S. Seiler</u> <u>6224 EASTERN AVE. BALTO., 21224, MD.</u> | | | |

Special Agent in Charge

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>66 09481</u> | |
|---|-------------------------------|---|------------------------------------|--|--|
| 66 09481 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>MRS. ELLA KNOX (ELIZABETH)</u> | | | | <u>SEPT. 18, 1966</u> <u>12:10</u> <u>pm</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>33RD AND CALVERT ST., BALTIMORE, MD 21201</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2904 SOUTHERN AVENUE</u> | | <u>27-03</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>7/18/82</u> | 9. AGE (In years last birthday) <u>84</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | 13. FATHER'S NAME <u>HERMAN HAASE</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE PLAGGMAYER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-03-1094B</u> | | 17. INFORMANT <u>FROM CHART</u> | |
| 18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CAR. RECTUM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>HEART FAILURE</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 10, 1966</u> to <u>SEPT. 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 18, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>R. M. C.</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. JOHN N. CLASSEN</u> | | 23D. ADDRESS <u>2923 ST. PAUL STREET, 18</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>9-21-1966</u> | 24C. NAME of CEMETERY or CREMATORY <u>Prospect Hill Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Towson, Baltimore Co</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>P. B. E. Fidler</u> | | 25C. FUNERAL DIRECTOR <u>Lorraine Funeral Home 7401 Belair Road</u> | |

DR. JOHN H. CLARK
243 ST. PAUL STREET, 18

x

SEPT. 18
SEPT. 18
SEPT. 18

No

HART FARMER
CAR. RECORD

from coast

AMIS PLADDERYS

HOUSEWIFE
AMERICAN

CANDIDATE
MARRIED

21/8/82
84

2404 SOUTHERN AVENUE
DARTMOUTH
THE LAMAR HOSPITAL
3230 AND CANTON ST. DARTMOUTH, MASS

CHANDLER

SEPT. 18, 1902
NEW YORK

M-436

66 09482

BALTIMORE CITY HEALTH DEPARTMENT

66 09482

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH T. MALTROTTI

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1966 9:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CERTIFICATE AMENDED

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1927 Homewood Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jly 12 1908

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Shauffer

10B. KIND OF BUSINESS OR INDUSTRY

Cith of Baltimore (Baltimore Md.)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Maltrotti

14. MOTHER'S MAIDEN NAME

Anna Porcella

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

II W.W.

16. SOCIAL
SECURITY NO.

219-03-2401

17. INFORMANT

ADDRESS

John Maltrotti-Brother-324 S.High St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Drowning
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

harbour

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Lancaster and Central Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Sept. 17, 1966 7:35

21E. INJURY OCCURRED

a.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

drove auto into harbour

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22-1966

23C. NAME of CEMETERY or CREMATORY

Balt. National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

322 S.High St.

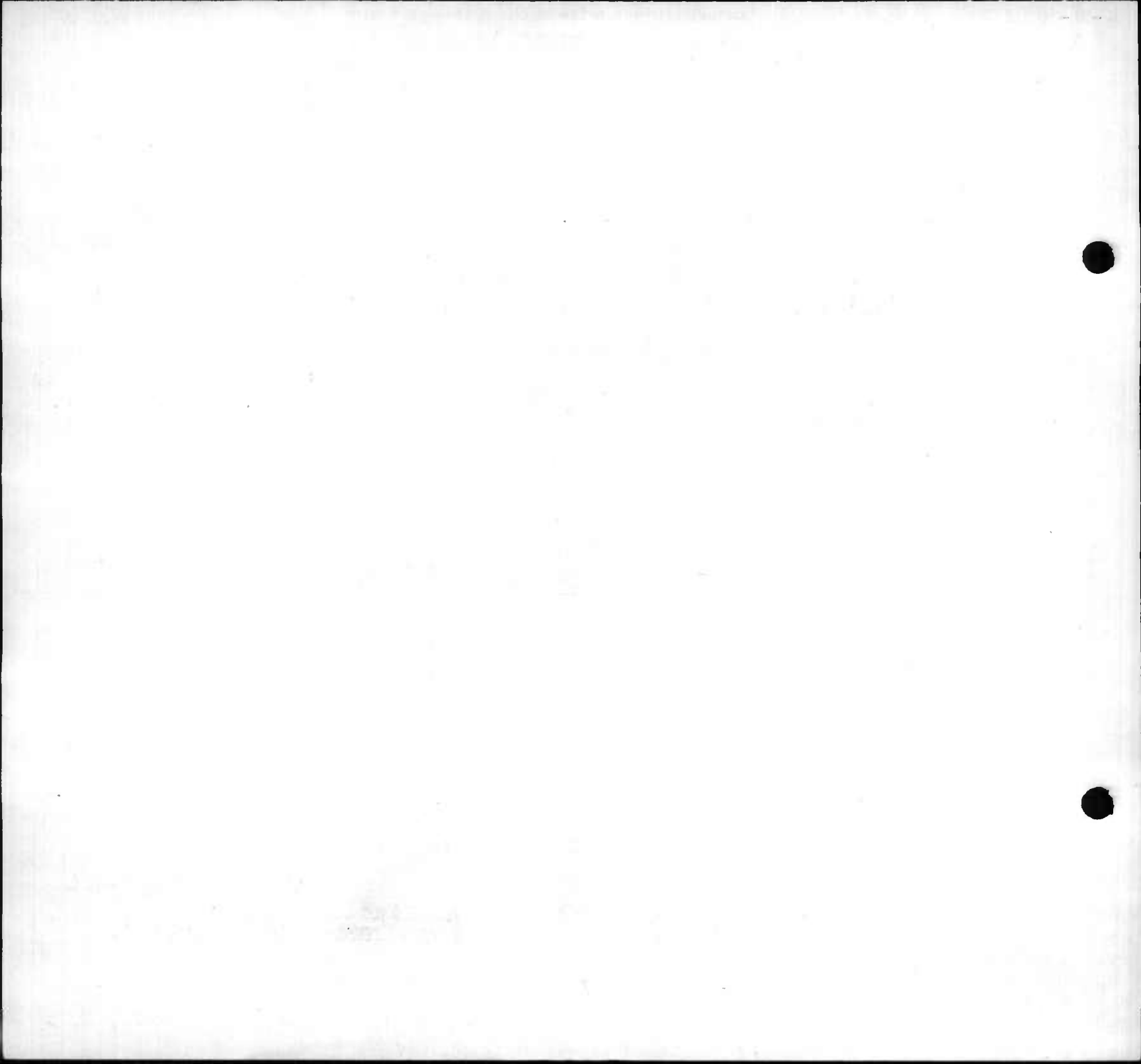
9/20/66 - Form from funeral ~~direction~~ director.

108c.

FUNERAL DIRECTOR: IMPORTANT

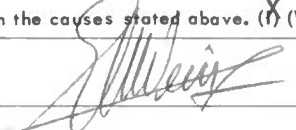
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------|--|-------------------------|---|-----------------------------|
| BIRTH NO. 66 09483 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09483 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) John J. Horan | | 2. DATE AND HOUR OF DEATH 9/17/66 9:30 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 EASTERN AVENUE BALTIMORE, MD. #21224 | | A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 904 N. Chester St. #21217 | | | |
| 5. SEX male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 9/5/06 | 9. AGE (In years last birthday) 60 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chamberlain | | 10B. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME unknown James S. Horan | | 14. MOTHER'S MAIDEN NAME unknown Margaret J. Freitag | | 12. CITIZEN OF WHAT COUNTRY? U.S. born | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO no | | 16. SOCIAL SECURITY NO. 217-38-7907 | | 17. INFORMANT RECORDS: ADDRESS #21224 BCM 4940 EASTERN AVE. BALTIMORE, MD. | |
| 18. 012,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) obstructive lung disease (chronic) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Pott's Disease | | 10 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/13/1966 to 9/17/1966, that (I) (we) last saw the deceased alive on 9/17/1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bruce M. Dow | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-17-66 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW | | 23D. ADDRESS BALTIMORE CITY HOSPITALS Balto. Md. 4940 EASTERN AVENUE #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (specify) Burial | | 24B. DATE 9-21-66 | | 24C. NAME OF CEMETERY or CREMATORY Moneland Memorial Park | |
| 24D. LOCATION Baltimore Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Fadden | | 25C. FUNERAL DIRECTOR Philip E. Crach 1211 Chesaco Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|---|--|
| BIRTH NO. 66 09484 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09484 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SCHAAF, JACQUE | | | 2. DATE AND HOUR OF DEATH 9/17/66 9:00 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 D. STREET ADDRESS (If rural, give location) 5504 CLIFTON AVE. | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11/24/03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) FLORIDA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME SAMUEL Lambert | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2 | | 16. SOCIAL SECURITY NO. 216.09.3855 | | 17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON AVE. | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Shock Myocardial Infarction, Acute ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/16 19 66 to 9/17 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/17 19 66 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED 9/17/66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. E. WEISS | | | | 23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial | |
| 24D. LOCATION Carroll County Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR R. E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS J. T. Starosty 6411 Winton Hill Rd. | |

ST. LOUIS, MO.

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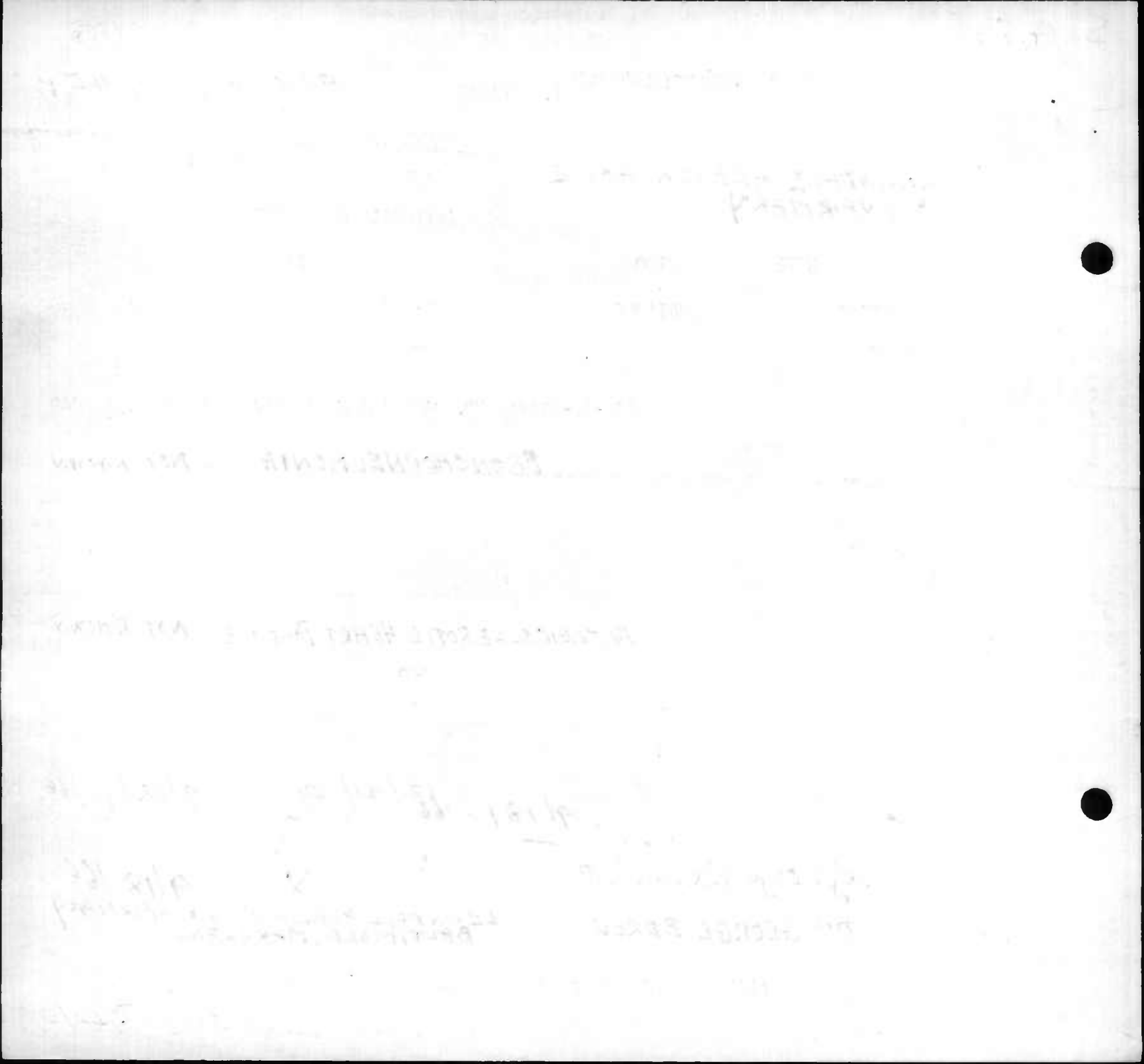
ST. LOUIS, MO.

ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-------------------------------|--|--|
| BIRTH NO. 66 09485 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09485 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) MAX SHULMAN | | 2. DATE AND HOUR OF DEATH 9/18/66 9.45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION LEVINDALE HEBREW HOME & INFIRMARY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) LEVINDALE AGED HOME | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 86 | 9. AGE (In years last birthday) 86 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | | 10B. KIND OF BUSINESS OR INDUSTRY BUILDER | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. 212-16-3724A | | 17. INFORMANT ADDRESS MR. SAMUEL SHULMAN 3545 MILFORD MILL ROAD | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC HEART DISEASE | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from 7/21/59 to 9/18/66 that (we) last saw the deceased alive on 9/18/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George Beran, M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) DR. GEORGE BERAN | | 23D. ADDRESS LEVINDALE HEBREW HOME & INFIRMARY BALTIMORE, MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/19/66 | | 24C. NAME OF CEMETERY or CREMATORY TZEMECH ZEDEK | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Robert E. Taylor | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09486 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09486 | |
|---|---------|--|----------------------|--|---|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Edward Alexander Gannon | | 9/18/66 7:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Union Memorial Hospital | | Maryland Baltimore City | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore 1410 KINGSWAY ROAD | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 812 REGISTER AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | Cau. | Married | 01-02-75 | 91 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED - TRANSPORTATION - RAILROAD | | | | BALTO, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Alexander Gannon | | Catherine Wiegand | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | A SECURITY NO. 88-4-189190 | | Mrs Marion Sullivan | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| ATELECTASIS | | Ateletasis of lung 1 day | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 9/12/66 | | Stone in Common Duct | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/9/1966 to 9/18/1966. The (we) last saw the deceased alive on 9/12/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23. SIGNATURE Charles H. Clansen, Jr. | | | | 23B. DATE SIGNED 9/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Douglas H. Stone M.D. | | | | 2921 ST Paul Street, Balt | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Entombment | | 9/21/1966 | | Greenmount Mausoleum Baltimore, Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 20 1966 | | Robert E. Talley | | H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | |

Entered American Genealogy

Married Baltimore City

Union Memorial Hospital 812 Register Ave

Mrs C. Married 01-07-72 at

Maryland U.S.

Alexander Gannon Catherine Wiegand

Residence Mrs. Mervin Sullivan

Atletate is of Maryland

912/66 270-1 in Common Out

911/8 66

911/8 66

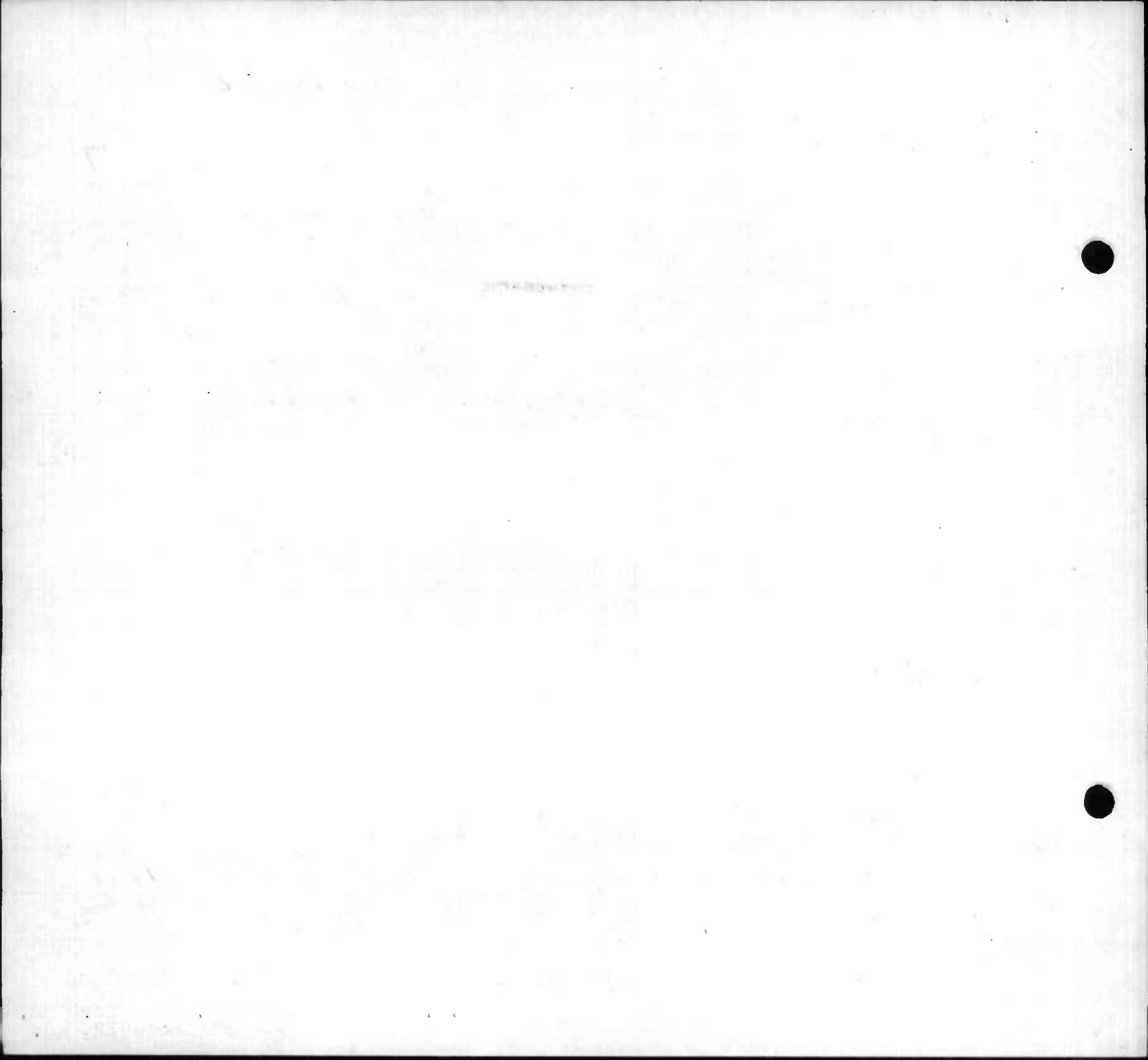


Charles H. Gannon

Boydles H. Stone 27 1525 27 401 Street, B.M.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 66 09487 | |
|--|-------------------------|--|------------------------------------|---|--|---|-----------------------|
| BIRTH NO. 66 09487 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Charles R. Johnson | | 2. DATE AND HOUR OF DEATH Sept. 19, 1966 2:58 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 14 27-38 D. STREET ADDRESS (If rural, give location) 1913 Lydenlea Way | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH 6/19/99 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METALLURGIST | | 10B. KIND OF BUSINESS OR INDUSTRY retired - STEEL | | 11. BIRTHPLACE (State or foreign country) Maryland LEANOR TOWN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James W. Johnson | | | | 14. MOTHER'S MAIDEN NAME GRANDE Georgia Le Griff | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213-07-4672 | | 17. INFORMANT ADDRESS JAMES W. JOHNSON - 3003 N. CHARLES ST. | | | |
| 18. CAUSE OF DEATH 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Hepatic coma INTERVAL BETWEEN ONSET AND DEATH 5 weeks | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Laennec's cirrhosis (B) DUE TO | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 13 1966 to Sept 19 1966 , that (I) (we) last saw the deceased alive on Sept 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Arthur M. Morris M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) Arthur M. Morris M.D. | | | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/1966 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | |



1
D 420

66 09488

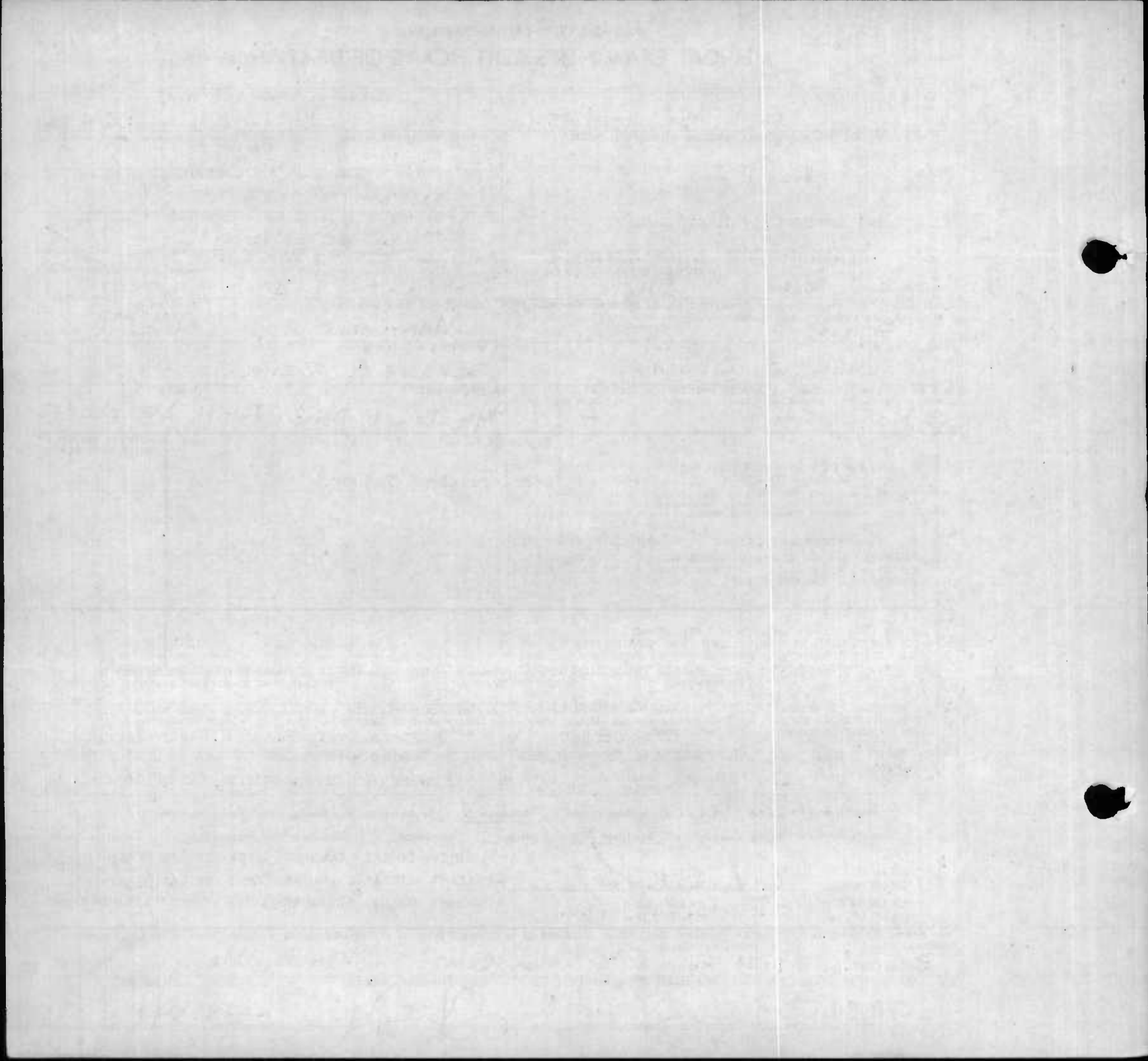
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-09488

BIRTH NO. M.E. CASE NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) ELAINE MARGARET DOLCH | | | 2. DATE AND HOUR PRONOUNCED DEAD September 17, 1966 2:35 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-01 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 704 N. Streeper Street | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 2-20-1949 | 9. AGE (In years last birthday) 17 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL | | 10B. KIND OF BUSINESS OR INDUSTRY - | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN W. DOLCH | | | 14. MOTHER'S MAIDEN NAME ELAINE R. WEHR | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | 17. INFORMANT ADDRESS Mrs. Elaine R. Dolch - 704 N. Streeper St. | | |
| 18. CAUSE OF DEATH 2817.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injury. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eastern Ave., E. of S. 46th Street 53-00 | |
| 21D. TIME OF INJURY (APPROX.) 9 17 '66 A | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Passenger in auto into fixed object. | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/17/66 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 9-20-66 | 23C. NAME of CEMETERY or CREMATORY OAK LAWN CEM. | | 23D. LOCATION (City, town, or county) (State) BALTO. MD. |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 24B. NAME OF REGISTRAR Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS Stanley Miller - 2334 Jefferson St. | |

VS 151-REV. 1/1/65



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---------------------------------|---|---|
| BIRTH NO. 66 09489 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09489 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FANNIE E. LAWRENCE | | 2. DATE AND HOUR OF DEATH 9-19-66 11:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL | | A. STATE B. COUNTY Baltimore, Maryland Baltimore | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 13 ELM STREET AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JAN 23 1885 | 9. AGE (In years last birthday) 81 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME FREDERICK CLAWS | | 14. MOTHER'S MAIDEN NAME JOSEPHINE WOLLER INC | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS MAURICE JOHN LAWRENCE 13 W ELM AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 420.01 | | CAUSE OF DEATH (A) DUE TO Atherosclerosis and hypertensive heart disease (B) DUE TO Congestive heart failure (C) — | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | INTERVAL BETWEEN ONSET AND DEATH at about 5 yr. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-19-66 1966 to 9-19 1966, that (I) (we) lost saw the deceased alive on 9-19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George Poveti | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) George Poveti | | 23D. ADDRESS Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEPT 22 66 | | 24C. NAME OF CEMETERY OR CREMATORY PARK WOOD CEM | |
| 24D. LOCATION (City, town, or county) (State) TAYLOR AVE BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR DIPPEL BROS INC | | ADDRESS 7110 BELAIR RD | | | |

CHURCH HOME & HOSPITAL

THOMAS WHITE

BLISS WIFE

FRANKLIN LEAVE

WIFE

1861

DAIRY 1887

BARTON'S

TOBACCO

WIFE

1887

1887

1887

1887

1887

1887

1887

George Bonetti

Church Home & Hospital

1887

1887

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 66 09490 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09490 | |
|--|---------------------|---|--|---|--|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) WALTER H. LEISURE | | | | 2. DATE AND HOUR OF DEATH SEPT. 18, 1966 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 433 WESTGATE RD. | | | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURA and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 433 WESTGATE RD. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-29-1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER | | | 10B. KIND OF BUSINESS OR INDUSTRY MD. NATL. BANK | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME LEISURE | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI | | | | 16. SOCIAL SECURITY NO. 215-18-2086 | | 17. INFORMANT ELAINE LEISURE 433 WESTGATE RD. | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Cardio-vascular disease DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH Unknown | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1. Bronchial asthma 2. Emphysema approx. 25 months. Unknown. | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/15 1965 to 9/13 1966 , that (I) last last saw the deceased alive on 9/13 1966 and that in (my) death applan death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE George W. Murgatroyd, Jr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/20/66 | |
| 23C. PHYSICIAN'S NAME (Type) George W. Murgatroyd, Jr., M.D. | | | | 23D. ADDRESS 1127 St. Paul Street, Baltimore, Maryland 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-21-66 | | 24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEM | | 24D. LOCATION (City, town, or county) (State) BALTIMORE COUNTY MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR D. E. Farley | | 25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE | | | |

8021-14-4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09491 | |
|--|---------|--|------------------|--|---|
| 66 09491 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | HAZEL COOK | | 9-13-66 9:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2340 MADISON AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| FEMALE | NEGRO | MARRIED | 9-20-01 | 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | None | | Cambridge MD | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY | |
| HENRY | | SARA JOHNSON | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 260XVI-204.0 | | CHRONIC UREMIA & ACUTE RENAL FAILURE | | 36+ HRS. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO | | | |
| | | (B) DUE TO | | ASCVD & INFECTED AK STUMP Aug 22 '66 | |
| | | (C) DUE TO | | DIABETES MELLITIS 30 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CHRONIC LYMPHOCYTIC LEUKEMIA | | 20+ yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 8/22/66 | | GANGRENE FOOT (LT.) | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-8 1966 to 9-13 1966, that (I) (we) lost saw the deceased alive on 9-13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Don Eugene Detmer | | | | 9-13-'66 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DON EUGENE DETMER | | JOHNS HOPKINS HOSPITAL, BALTO, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-17-66 | | Mt Auburn | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| Baltimore | | MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 20 1966 | | R. E. F. F. F. | | Stetson D. Wilson | |

1875

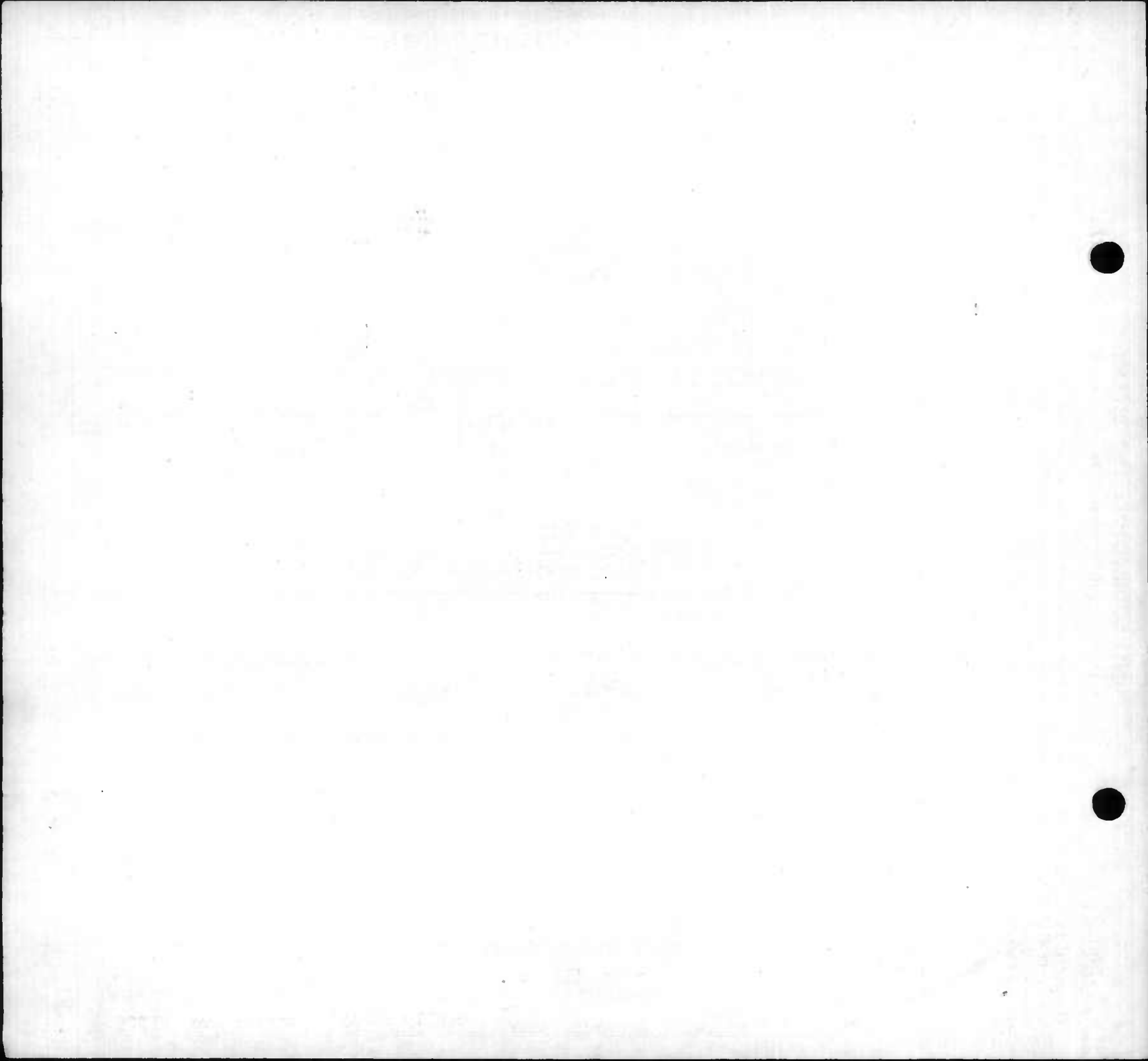
1876

1877

FUNERAL DIRECTOR: IMPORTANT

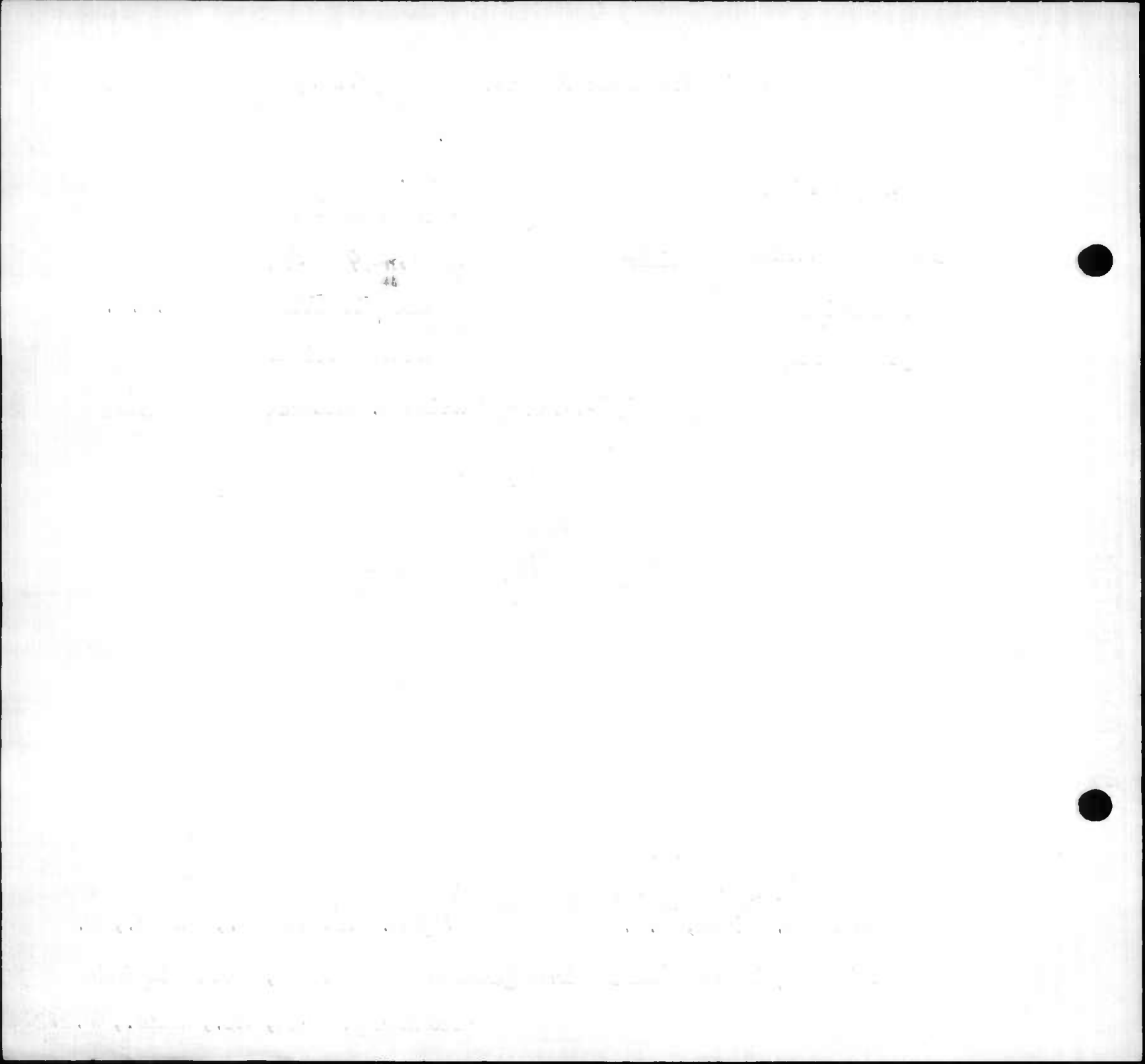
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09492 | |
| BIRTH NO. 66 09492 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Kleinsmith, Martin | | 17 Sept. 1966 9:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION University of Md. Hospital | | A. STATE Maryland B. COUNTY 96 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Orchard Beach 52-00 | |
| | | D. STREET ADDRESS (If rural, give location) 7903 Seabreeze Dr. | |
| 5. SEX Male | 6. RACE Can. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 4 April 1904 |
| | | 9. AGE (In years last birthday) 62 yrs. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired fireman | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Frederick. Kleinsmith | | 14. MOTHER'S MAIDEN NAME Mae Claudry | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Family |
| | | ADDRESS Same | |
| 18. 465X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MASSIVE UPPER GI BLEEDING ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Stress ulcer | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Pulmonary embolism | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic bronchitis, Pulmonary Emphysema | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 9 Sept. 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Pulmonary Embolism | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 Sept 1966 to 17 Sept 1966 , that (I) (we) last saw the deceased alive on 17 Sept 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE DeLamora, C. D. | | 23B. DATE SIGNED 17 Sept. 1966 | |
| 23C. PHYSICIAN'S NAME (Type) DeLamora, S. Santos | | 23D. ADDRESS As above | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/66 | |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem. | | 24D. LOCATION (City, town, or county) (State) AA Co Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR McCully FH | | 25D. ADDRESS 237 Patapsco Ave 21225 | |



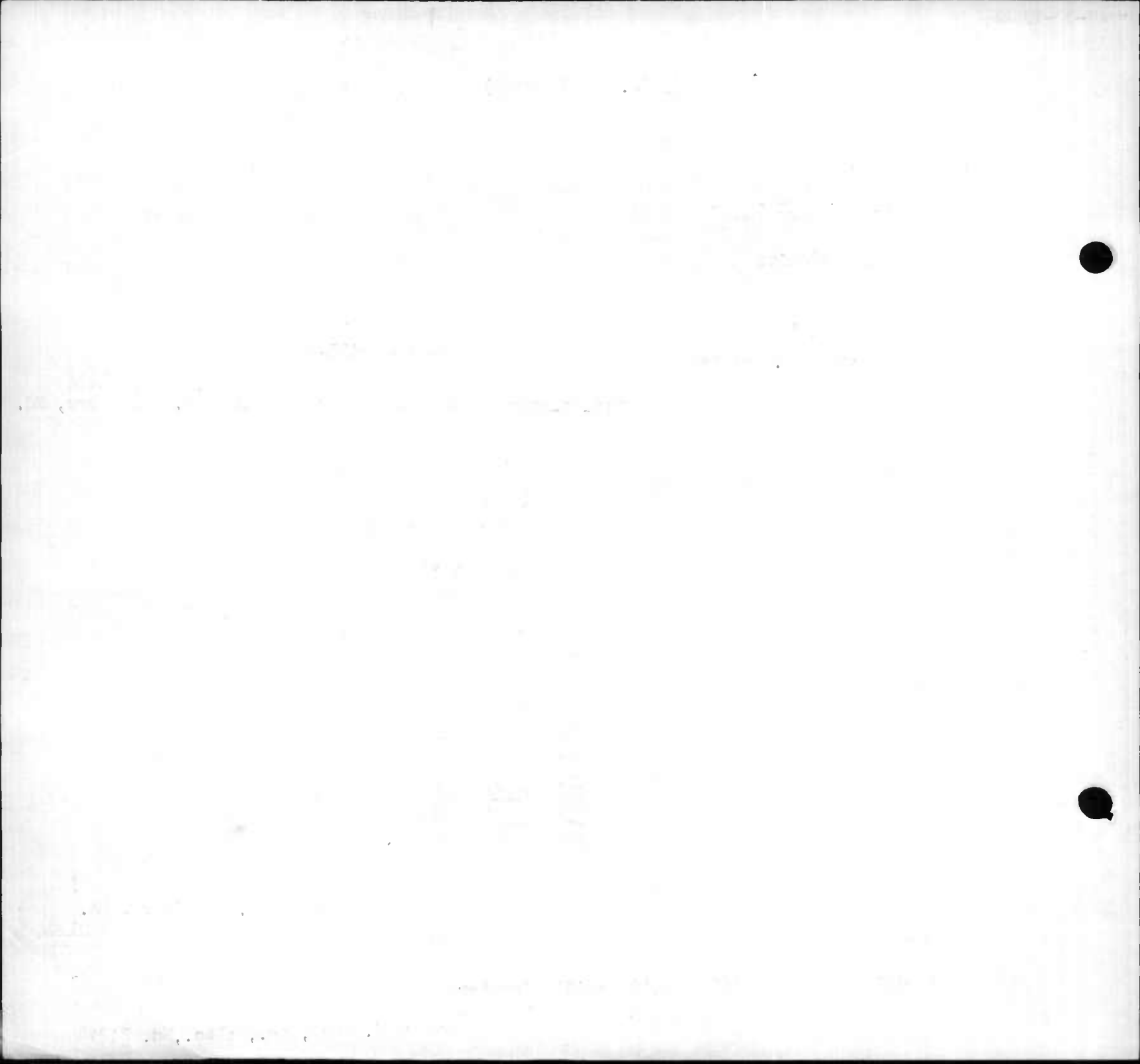
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|--|---|--|
| BIRTH NO. 66 09493 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 66 09493 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mattie Charlotte Parrack | | 2. DATE AND HOUR OF DEATH 9/18/1966 1:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3119 Berkshire Road | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 3119 Berkshire Road | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH May 23, 1879 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME Eli Wamsley | | | 14. MOTHER'S MAIDEN NAME Martha Daniels | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 2320907440 | | 17. INFORMANT Adrian R. Parrack | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Gen. Arteriosclerosis (C) Hypertension | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs 16 yrs 16 yrs |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-14-1950 to 9-18-1966 , that (I) (we) last saw the deceased alive on 9-18-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 1:40 P.M. | | | | | |
| 23A. SIGNATURE Robert H. Siver | | | | 23B. DATE SIGNED 9-19-66 | |
| 23C. PHYSICIAN'S NAME (Type) Robert H. Siver, M.D. | | 23D. ADDRESS 3105 N. Charles St., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/66 | | 24C. NAME OF CEMETERY or CREMATORY Odd Fellows Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Elkins, West Virginia | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Robert E. Feltner | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

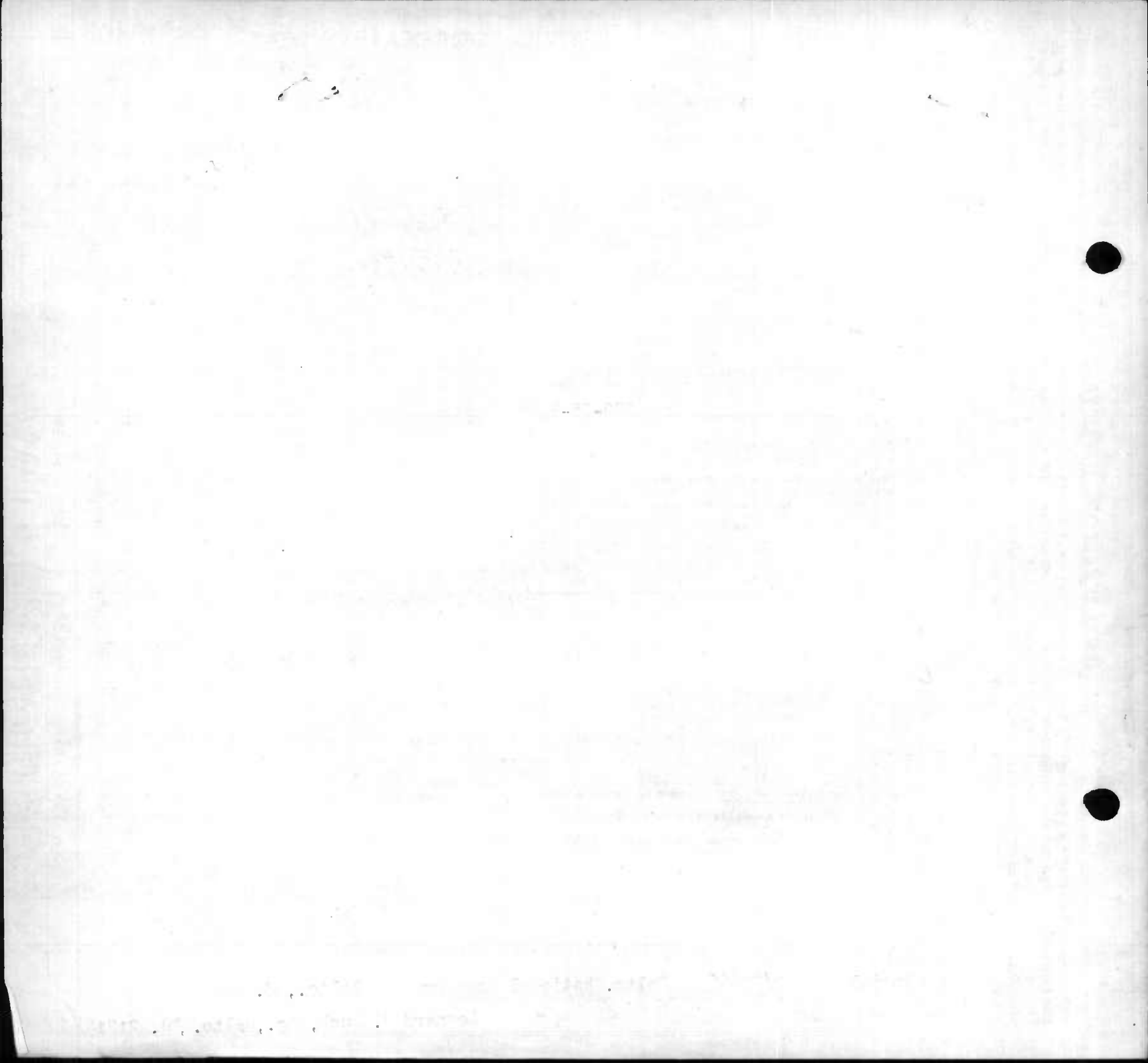
| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 652 66 09494 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09494 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) FRANK, ETHEL (J. ETHEL FRANK) | | | 2. DATE AND HOUR OF DEATH 9/18/66 16:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | A. STATE MARYLAND B. COUNTY - C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 322 E. 26th ST # 21218 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4/29/79 | 9. AGE (In years last birthday) 87 | 10. If Under 1 Yr. Months Days Hours Min. 12-23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Charles F. Beachamp | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. F2 712-05-5759 | | |
| 17. INFORMANT BCH; Records 4940 Eastern Ave. Baltimore, Md. | | | ADDRESS # 21224 | | |
| 18. 720.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ? Pulmonary Embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Myocardial Infarction ASCVD | | | INTERVAL BETWEEN ONSET AND DEATH ? | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. URINARY TRACT INFECTION | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 19 66 to 9/18 19 66 , that (I) (we) last saw the deceased alive on 9/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard D. Maffezzoli M.D. | | | | 23B. DATE SIGNED 9/18/66 | |
| 23C. PHYSICIAN'S NAME (Type) MAFFEZZOLI, RICHARD D. M.D. | | | | 23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. BALTIMORE CITY HOSPITALS # 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Beckleyville Cemetery | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert C. Conroy | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09495 | |
|---|------------------|---|----------------------------------|--|---|
| BIRTH NO. 66 09495 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HESS MARY | | | |
| 2. DATE AND HOUR OF DEATH 9/19/66 12⁰⁵ A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2904 HALCYON AVE. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/7/1905 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME THOMAS LYONS | | 14. MOTHER'S MAIDEN NAME CATHERINE KIRK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-05-3368 | | 17. INFORMANT ADDRESS THEODORE HESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 121X I | | CAUSE OF DEATH MALNUTRITION, DEHYDRATION | | INTERVAL BETWEEN ONSET AND DEATH ? WEEKS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) CONGESTIVE FAILURE DUE TO AND RENAL FAILURE | | | |
| | | (B) ARTERIOSCLEROTIC C.A.D. - STATUS DUE TO POST CA OF CEREBRAL WITH | | 2 YEARS | |
| | | (C) STATUS POST IRRADIATION THERAPY lobar pneumonia pneumal effusion | | 2 YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 9/16/1966 to 9/19/1966 , that (I) (we) last saw the deceased alive on 9/18/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE John P. Doerfer | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN P. DOERFER | | 23D. ADDRESS MARYLAND GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/66 | | 24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, MA | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214 | | 25D. ADDRESS | | | |



47-73-46 1N-610 66 09496

BALTIMORE-CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 09496

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|------------------|---|-----------------------------|--|------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Charles H. Murphy | | 9-19-66 4:30 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224 | | | | MARYLAND | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 2703 LOUISE AVENUE / 11 / 21212 6809 Sturbridge Dr. Balto. Md. 21224 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months Days | 11. UNDER 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? |
| Male | White | DIVORCED | 5-30-1899 | 45 66 | | | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | Paint Foreman | | MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| HENRY MURPHY | | | | Agnes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | RECORDS: BCH 4940 Eastern Ave. Balto. Md. 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| E933157002.1 | | | | Hypothermia | | 3 days | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Due to | | | |
| ANTECEDENT CAUSES | | | | Due to | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Due to | | | |
| II | | | | Tuberculosis. | | 10 yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | yes | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | street | | Baltimore City | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 9 7 67 ? | | While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | Exposure due to weather condition | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-19-66 19 to 9-19-66 19, that (I) (we) last saw the deceased alive on 9-19-66 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| William A. Emerson | | | | 9-19-66 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| WILLIAM A. EMERSON | | | | BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO. MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/22/66 | | Moreland Memorial Park | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 20 1966 | | Robert E. Farley, MD | | Leonard J. Ruck, Inc., Balto., Md. 21214 | | | |

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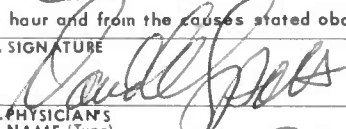
10/10/10

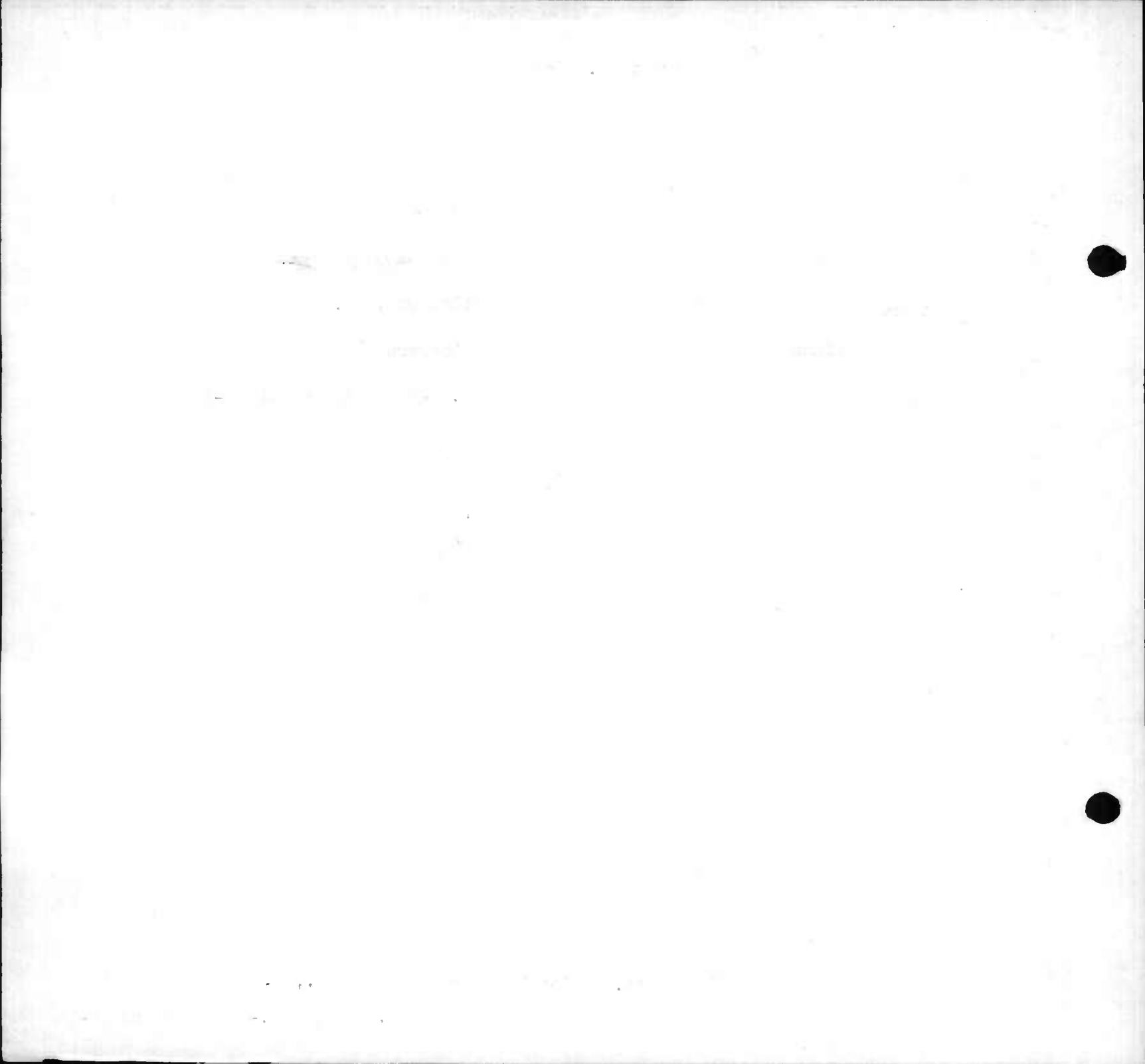
10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 66 09497 | |
|---|---------------------|--|---|--|---|--|--|--|---------------------------------------|-------------------------|--|
| BIRTH NO. 66 09497 | | | | | | | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) STAINES, CLARENCE | | | | | 2. DATE AND HOUR OF DEATH 9/18/66 16:05 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location) | | | | | A. STATE MARYLAND | | | | | | |
| | | | | | B. COUNTY BALTIMORE | | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1318 ASBURY Rd | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 5/27/1899 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY B & O RR | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME John Staines | | | | | 14. MOTHER'S MAIDEN NAME Margaret Kenney | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes | | | 16. SOCIAL SECURITY NO. X | | 17. INFORMANT Mrs. Marien Staines (wife) | | | ADDRESS -1318 Asbury Road | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MI - CARDIAC ARREST | | | | | (A) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH 15 yrs | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO ASHD | | | | | | |
| | | | | | (C) DUE TO | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/18 19 66 to 9/18 19 66 , that (I) (we) last saw the deceased alive on 9/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE  | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/18/66 | | | |
| 23C. PHYSICIAN'S NAME (Type) D.A. SPOTT | | | | | 23D. ADDRESS Sinai Hosp | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9/21/66 | | 24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery | | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR Robert E. Farber | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. | | | ADDRESS -5305 Harford Rd-14 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 66 09498 | |
|--|-------------------------|--|--|--|---|
| BIRTH NO. 66 09498 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY S. HARDY | | 2. DATE AND HOUR OF DEATH Sept. 17, 1966 8:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bel Aire House In The Pines Nursing Home 5837 Bel Air Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 5504 Carter Avenue - 14 | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH June 18, 1900 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk...sales | | 10B. KIND OF BUSINESS OR INDUSTRY Stewart & Co. | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Hans Skalberg | | 14. MOTHER'S MAIDEN NAME Elizabeth Avon | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 228-09-2136 | | 17. INFORMANT Mrs. Elizabeth Moore (dtr) ADDRESS Belair, Md. - 41 Homestead St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Aspirin Poisoning (B) Transition (C) Senile Psychosis Fracture of rt. hip | | INTERVAL BETWEEN ONSET AND DEATH 10 days months years 1 month. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/27 19 66 to 9/17 19 66 , that (I) (we) last saw the deceased alive on 9/17 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | | 23B. DATE SIGNED 9/19/66 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley | | | | 23D. ADDRESS 4900 Belair Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-20-66 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1966 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - 5305 Harford Road | |
| | | | | ADDRESS | |

10/10/10

Wm D. Smith

10/10/10

10/10/10

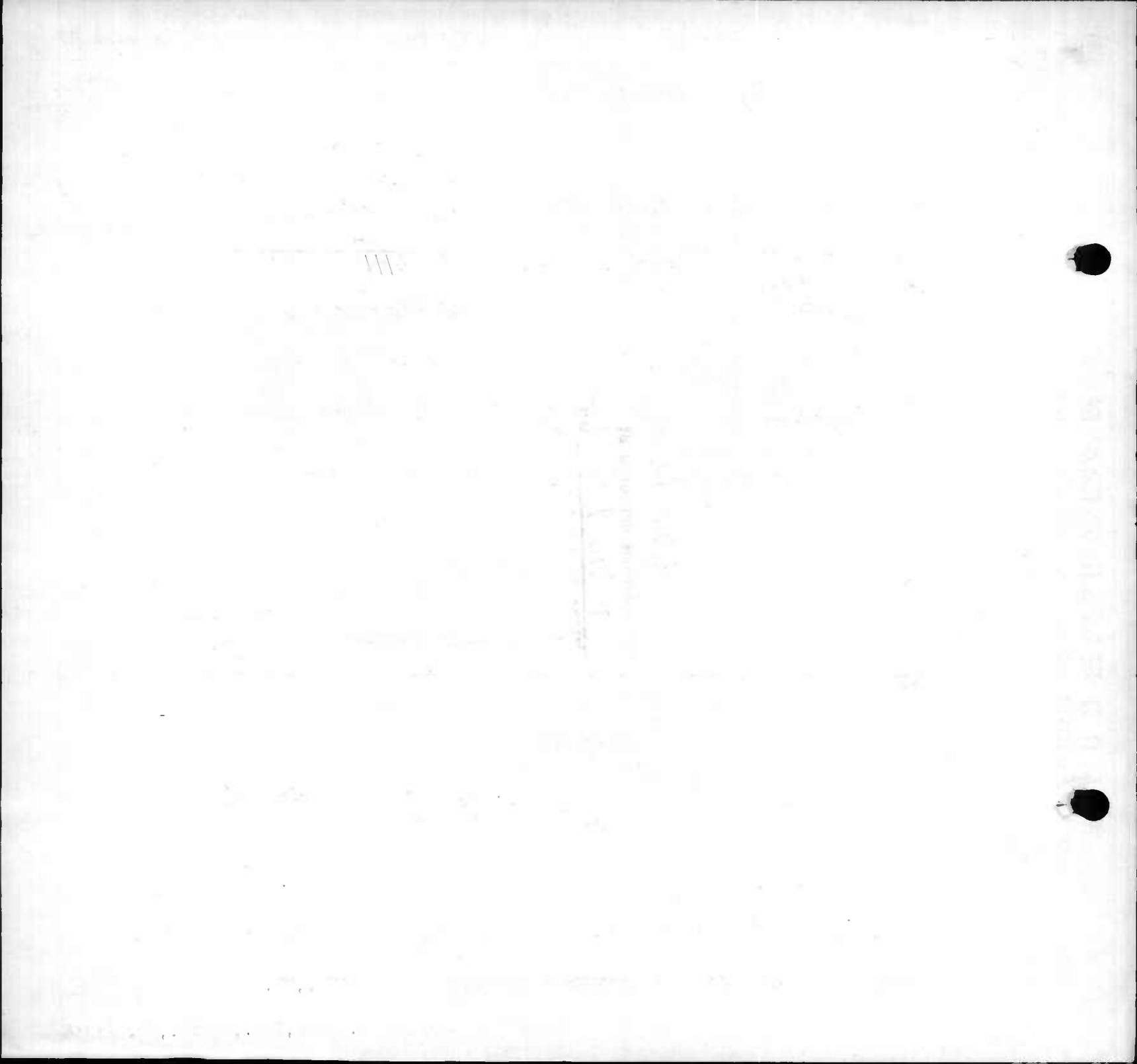
10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|--|---|
| BIRTH NO. 66 09499 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 66 09499 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>ARBOGAST, ELLEN R.</u> | | | Sept. 19, 1966 8-15 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Montebello State Hospital</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-04</u> D. STREET ADDRESS (If rural, give location) <u>128 Willard St.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>2/23/07</u> | 9. AGE (In years last birthday) <u>59</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>William Arbogast</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Anna J. Hoar</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>253 90-2220</u> | | | 17. INFORMANT <u>Medical Records</u> | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH <u>Carcinomatous</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 12</u> 19 <u>66</u> to <u>Sept 19</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>BARRY N. ROSENBAUM</u> | | | 23B. DATE SIGNED <u>9/19/66</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>BARRY N. ROSENBAUM</u> | | | 23D. ADDRESS <u>MONTABELLO HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/21/66</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>NEW CATHEDRAL CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) <u>BALTO., MD.</u> | | 24E. NAME OF REGISTRAR <u>Robert E. Farber</u> | | 24F. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC., BALTO., MD.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1966</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC., BALTO., MD.</u> | |



66 09500

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 09500

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William G. McLaughlin

2. DATE AND HOUR PRONOUNCED DEAD

9/15/66 7:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

509 E. 38th St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Pier 4 - Pratt St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 15 66 6:20p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

jumped into harbor

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M. D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/66

23C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, City,

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Richter & Sons Inc. North Penna Ave

ADDRESS

WALL BY FORCE
TO BE CONTENT

5-1